Counselling Referral Form

Please fax or send completed referral forms to the Counselling Manager at:
Age UK Manchester
20 St Ann's Square, Manchester M2 7HG
Tel: 0161 833 3944
Fax: 0161 833 3945
Email: counselling@ageukmanchester.org.uk

Client's Details

Title		Male/Female	Tel Home Mobile	
Forename			Surname	
Date of Birth			Age	
Address Postcode				
Email				

- Does the client know they are being referred?..**Yes** / **No**
- Can contact be made to the client's home by telephone?............................**Yes** / **No**
- Is the client a carer?...**Yes** / **No**
- Does the client live alone?...**Yes** / **No**
- If no, please specify who with:…………………………………………………………..
- Is a home visit requested? (Only considered if housebound)…………………**Yes** / **No**

Referrer's Details

Name		Address
Occupation/ Relationship		
Tel		Postcode
Fax		Email

GP's Details

Name		Medication taken (Please print clearly): -
Practice		
Address Postcode		
Tel		
e-mail address		

Reason for Referral

Does the person have any communication problems such as language, illiteracy, hearing or visual impairments? (Please give details)

……………………………………………………………………………………………………….

……………………………………………………………………………………………………….

Has the client had any previous counselling?..**Yes** / **No**

If yes, please give details: -

Agency	
Counsellor	
Dates & Duration	

Please give details of any known psychiatric history or any other information you think may be relevant. E.g. Physical health problems

Risk Assessment

Please note, if the following questions are not answered fully, we may be unable to offer counselling.

Self Neglect	YES / NO / UNKNOWN	Further Comments: -
Accidental Harm	YES / NO / UNKNOWN	
Intentional Self Harm	YES / NO / UNKNOWN	
Abuse from others	YES / NO / UNKNOWN	
Violence/Aggression	YES / NO / UNKNOWN	
Environmental Hazards	YES / NO / UNKNOWN	
Any other risk factors*	YES / NO / UNKNOWN	

* If yes, please state under further comments.

Reason for referral to Age UK Manchester Counselling service: -

No counselling service available for people over 60 years of age □

No other counselling service offers home visits □

The client has come to the end of fixed term counselling (6 weeks) offered by a GP (or other) □

Other reason (please specify)……………………………………………………………………….

Where did you hear about our counselling service?...

……………………………………………………………………………………………………….

Signed:………………………………………………Date:………………..