



Project 7

Young People's Counselling Service

Referral Form

Name of client; _____
D.O.B; _____
Address; _____
Postcode; _____
Tel; _____
Mobile; _____

Referred by; _____ Position; _____
Reason for referral; _____

Name of GP and
address of practice; _____
Tel; _____

Are parents aware
of referral? Y / N

Personal history;

History of violence? Y / N _____

Substance misuse? Y / N _____

Self harm? Y / N _____

In education? Y / N _____

Disability? Y / N _____

Housing status? _____

Signed; _____

Date; _____