REFERRAL FORM FOR COUNSELLING

(Age range 12 – 25)

LOTTERY FUNDED

Date Received: Reference:

Young Person requesting counselling to complete (with assistance if necessary)

Personal Details			
First Name:	**«Forename»**	**Surname:**	**«Surname»**
Date of Birth:	**«Date_of_birth»**	**Age:**	**«Patient_Age»**
Contact Address: «Patient_address_house» «Patient_address_road» «Patient_address_post_town» «Patient_post_code» *Are you happy for us to write to you at the address if necessary?* ***Yes*** ☐ ***No*** ☐		**Home phone no:** «Patient_home_telephone_number» *Are you happy for us to leave a message at the above number if necessary?* ***Yes*** ☐ ***No*** ☐ **Mobile no:** **«Patient_mobile_telephone_number»** *Are you happy for us to leave a message at the above number if necessary?* ***Yes*** ☐ ***No*** ☐	
If you are happy for us to send you messages by email, please enter your email address here:			

What is your preferred method of contact?

What is the best time for us to contact you?

What is your preferred time for an appointment e.g. evenings/afternoons?

Is there any other relevant information that would assist us in contacting you to arrange an appointment?

Where did you hear about counselling at 4YP?

If you have the support of a third party and are happy for us to contact them if we have any problems contacting you to arrange an appointment please provide their details here:

Contact Name: Agency:

Address:

Telephone Number:

I consent for the above information being processed for counselling, and that I understand that I will be contacted when the next available counselling appointment becomes available.

Signed*:* *Date:*

Registered Charity Number 1084286
Registered Company Number 3954918

Please return to: 14 Lower Brook Street, Ipswich
IP4 1AP
Tel: 01473 252607
Email – enquiries@syphp.org.uk
Web: www.onesuffolk.co.uk/4yp