**Children Services - Counselling Referral Form**

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| --- |
| Office use/Client ID: |

CONFIDENTIAL

**Please complete the form as fully as possible and return (clearly marking it CONFIDENTIAL) to:**

**Hear Me, Referrals, PO Box 7010, Forfar. DD8 0BJ**

***(This form will NOT be accepted unless signed by an adult aged 18 or over)***

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| --- | --- |
| **Child’s Name:** | **Age: Gender:** |
| **Parent(s)/Carer’s Name:** | **Referrer’s Name:** |
| **Child’s Home Address:** | **Referrer’s Address:** |
| **Telephone Number:** | **Telephone Number:** |
| **Email:** | **Email:** |
| **Permission to leave a message (Please circle):**  **YES NO** | |

|  |  |
| --- | --- |
| **Name of GP and/or GP surgery:** | |
| **Are there any medical issues we should be aware of: YES NO**  **If YES please provide more details:** | |
| **Adult signature**  **(Aged 18 or over) ………………………………………………………………………..............**  **What is your relationship to the child or young person? ……………………………………………..** | |
| **OFFICE USE ONLY** | |
| ***Date received:*** |  |
| ***Referral processed by:*** |  |
| ***Contact made?*** |  |