



CONFIDENTIAL
Referral Form for Assessment by
Herefordshire Mind
COUNSELLING AND PSYCHOTHERAPY SERVICE

CLIENT SURNAME: **CLIENT FIRST NAMES:**

DATE OF BIRTH: **GENDER:**

ADDRESS & POST CODE:

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TEL. NUMBERS: Daytime: Evening Mobile:

Any confidentiality issues around contact?

Reason for referral

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Other agencies: Has client received or is client receiving support from any other agency, CMHT etc?

If yes, please provide details:

Medication: Is client prescribed medication?

If yes, which?

How did you /client hear of our Service?

Any other comments:

.....

Referrer's role in relation to client :

Name: **Contact telephone:**

Date of referral:

Address:

Please send this form to:
Herefordshire Mind Counselling and Psychotherapy Service
26a St. Owen Street, Hereford. HR1 2PR
Marked for the Private and Confidential attention of Mr Ian Kirkpatrick.
Or Facsimile: 01432 344975 (confidential). Tel: 01432 261493
Email: cpservice@herefordshire-mind.org.uk