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**Counselling and Listening Referral Form**

Details of person requesting counselling / listening service

|  |  |
| --- | --- |
| Name:  |  |
| Address: |  |
|  | Date of birth:  |  |
| Home No:  |  | Mobile: |  |
| Email address:  |  |
| Best method of contact: | Home / Mobile / Email*Please circle all that apply* |
| Is the person aware of the referral? | Yes / No / Self-referral |
| Can the counsellor contact direct? | Yes / No / Self –referral |
| Can the counsellor leave a message? | Yes / No |
| Counselling or Listening appointment required? |  |
| Is there a preferred day or time to contact? |
| ***If self-referral*** – how did you hear about A Time 2 Talk? |

Referrer details ***(leave blank if a self-referral)***

|  |  |
| --- | --- |
| Name:  |  |
| Organisation name & address: |
| Contact No:  |  |
| Email address:  |  |
| Are you aware of any safeguarding issues? | Yes / No |
| If yes please give full details: |

**Referrer signature ……………………………….……. Date ……………**

**Please forward to:**

A Time 2 Talk, Disability North, The Dene Centre, Newcastle upon Tyne NE3 1PH