****

***For Compass use only***

*File no:*

*Assessment Date: / / Time:*

*Referral Taken By:*

*Date:*

*Counsellor:*

*1st Session Accepted:*

# Surviving to Thriving - Referral Form

**Telephone Counselling [ ] Video Counselling [ ]**

Name:

|  |
| --- |
|  |

Address & Postcode:

|  |
| --- |
|  |

DOB (must be 18+):

Gender: Male/Female/Other/Prefer Not To Say

Can we contact you/leave a voicemail? Yes/No

Can we text you? Yes/No

Can we contact you via email? Yes/No

Mobile Telephone No:

Home Telephone No:

Email address:

Mobile No……………………………………

|  |  |
| --- | --- |
| Would you like a leaflet explaining the support programme? Yes / No If Yes, by Post or Email | Leaflet Sent [ ]  (Tick when Sent)Date Sent |

GP Details

|  |
| --- |
|  |

Previous counselling or involvement with mental health services

|  |
| --- |
|  |

Are you engaged with any other support services at the moment?

|  |
| --- |
|  |

Diagnosed with Mental Health Conditions? (GP/ Psychiatrist Diagnosis)

|  |
| --- |
|  |

Current medication

|  |
| --- |
|  |

Do you have any previous convictions for sexual offences or is there a current investigation? Yes/No

Do you have a history of violence towards others? Yes/No

Availability

|  |
| --- |
|  |

Do you need an interpreter? Yes/No

First language:

Where did you hear about Compass? NHS Friend / Family Other Agency

(Please highlight in bold) Internet Other (Please specify)

**Please send referral to** **enquiries@compass-counselling.org.uk**

**Registered office: 151 Dale Street, Liverpool, L2 2AH**