



For Compass use File No _____
 Referral Ass Date.....
 Taken by Cllr ..
 Date 1st Session.....
 Accepted ..

Referral Form

Name:

Address & Postcode:

DOB:..... (must be 18+)

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

Contact Telephone No:Can we contact you/leave a voicemail Yes/No.

Mobile No.....Can we text you? Yes/No

Email address:.....

Can we contact you by email? Yes/No

GP Details

Previous counselling or involvement with mental health services

Current medication

What difficulties have brought you to counselling? How long have you experienced them?

What is your availability?

What is your first language?Do you need an interpreter?.....

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

Please circle Internet Other (Please specify)

Send referral to: Fax 0151 237 3994 or e-mail: enquiries@compass-counselling.org.uk

Registered office: 151 Dale Street L2 2AH