Compass counselling services

For Compass use File No ________
Referral
Taken by ....
Date ....

Anger Management LIVERPOOL Referral Form

Name of Client:

Address & Postcode:

DOB:______________ (must be 18+) Age: _______ Gender: Male/Female/Other/Prefer Not To Say

Contact Telephone No: ________________________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

Relevant Medical/Personal History (including psychiatric referrals and any current medication)

Literacy Issues? Yes ❑ No ❑ ____

History of substance misuse? Yes ❑ No ❑ ____

Risk of harm to others? Yes ❑ No ❑ Risk of harm to self? Yes ❑ No ❑

Are there children present in the home? Yes ❑ No ❑ (Please give details)_______________________

Has the client agreed with this referral? Yes ❑ No ❑ ____

Details of Referrer (Name, Organisation, Contact Details)

Date of Referral: ____

Send referral to: Fax 0151 237 3994 or e-mail: enquiries@compass-counselling.org.uk
Registered office: 151 Dale Street, Liverpool, L2 2AH