SOLITUDE
counselling service

Referral form

CLIENT DETIALS			
Name:		**Date:**	
DOB:		**Contact:**	
Emergency contact:		**Email:**	
REFERRER DETIALS			
Name:		**Contact:**	
Practice/ Organisation:		**Relationship with client:**	

Personal History/ Reason for referral (eg childhood, substance abuse, relationship history, coping with previous stressors)

Risk Assessment			
Suicidal Ideation		**Suicidal Intent**	
Current Plan		**Risk to Others**	

Client have given consent on the above information and fully acknowledged this referral.	YES ☐ NO ☐

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Solitude c.s.