

ADULT COUNSELLING REFERRAL FORM

**Referral Details** Date:

Name of Referrer: Referrer Organisation: Referrer Email Address: Client Reference Number (If applicable): Name of Client: D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Phone No: Client Email Address:

# Client Parental Status

Yes / No

Is Client Pregnant?

(If Yes) Expected due date:

Current No of Children

Age of youngest child

**Client Housing Status** (Insert Yes / No)

|  |
| --- |
|  |
|  |
|  |

Risk of homelessness Registered as homeless Residing in family hub

Other: (Please specify)

**Client Availability** (Insert Yes / No)

|  |
| --- |
|  |
|  |
|  |

Is the client aware of this referral?

Client gives permission to be contacted by phone Is this counselling referral urgent?

If yes, why urgent?

# Return completed form to:

Email: [dawn.kenny@anew.ie](mailto:dawn.kenny@anew.ie)

By Post: Counselling Service, 113 Pearse Street, Dublin 2. D02 AV80

*Please Note: Anew Counsellors do not see clients for counselling if they are simultaneously engaged in counselling with another service.*