|  |
| --- |
| **When the form is complete, please only fax the form to 679 9740 or email a scanned copy to referrals@spectrum.life** |
| Name of employee:  |  | Date:  |  |
| Organisation name  |  | Gender:  |  Male Female  |
| Job title of employee:  |  | Employee’s D.O.B:  |  |
| Tel no. where employee can be contacted:  | Home:  | Mobile:  |  |
| Location/address:  |  | Postcode:  |  |
| Reason for referral:  |  |
| **Trauma response**: Yes No  |
| Other relevant issues to be considered:  |  |
| Is Employee off work Yes No If yes, since when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any previous counselling for this presenting issue? Yes No If yes, when was this? Available days/times for counselling appointments:  |
| Name & job title of Referrer:  |  |  |  |
| Address of referrer:  |  |  | Postcode:  |  |
| Tel no:  |  | Email:  |  | FAX:  |  |

**Please sign below to confirm consent for Spectrum Life to make contact with the individual concerned.**

**Should the individual not be available to sign, please make sure they have consented before sending referral:**

**Signed by Employee**:………………………………………… **Date**: …………………….. **Signed by Referrer**:………………………………………… **Date**: ……………………..