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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**: ……………………..