**Referral Form**

Please fill in the form with all your relevant information after the colon
When the form is complete email a copy to referrals@spectrum.life

Name: ………………………………………………………………

Organisation: ………………………………………………………

Date of referral: ……………………………………………………
Reason for referral: ……………………………………………….

Contact details: ……………………………………………………

Contact number: ……………………………………………………
Preferred method of contact: ……………………………………

Does the employee have a disability (if yes please give details):

………………………………………………………………………………

………………………………………………………………………………

Are any reasonable adjustments needed when accessing the service (please give details):

………………………………………………………………………………

………………………………………………………………………………

Has the employee consented to this referral (if yes please give details):

………………………………………………………………………………

………………………………………………………………………………

Available days/times for counselling appointments:
………………………………………………………………………………

………………………………………………………………………………

**About the referrer**

Name: ……………………………………………………

Job: ………………………………………………………

Email: ……………………………………………………

**Please sign below to confirm consent for Spectrum Life to contact 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**: ……………………...

Information kept on file is purely for the purpose of providing you with support and is only accessed by the Case Management team of the service, all of whom are Psychotherapists and who adhere not only to our guidelines but also to those of their Accrediting bodies.

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