relate
the relationship people

RELATE Coventry and Warwickshire
Adult Counselling Service Inter-agency Referral Form

Please complete this form by giving as much information as possible to help us in our assessment of the clients you are referring. Thank you.

Section 1: To be completed by referring agency	
Name & address of referring agency:	**Date:**
Contact details: Email address: Telephone number:	
Name of referrer:	**Role:**

Section 2: Details of clients referred

Please tell us how many clients you are referring and their relationship to each other

Please make it clear who will be attending the appointments

	Adult client 1	**Adult client 2**
Name		
Date of birth		
Gender		
Address		
GP /health centre		
Tel Numbers	Mobile: Email address:	Mobile: Email Address:

	Adult client 3	Adult client 4
Name		
Date of birth		
Gender		
Address		
GP /health centre		
Tel Numbers	Mobile: Email address:	Mobile: Email address:

Details of the clients children

	Child 1	Child 2	Child 3
Name			
Date of birth			
Address			
Gender			
Child of C/W/M			

	Child 4	Child 5	Child 6
Name			
Date of birth			
Address			
Gender			
Child of C/W/M			

Section 3: Reasons for referral
Why have you referred the clients at this time?
What does the individual / couple hope to achieve by this referral?
Service being requested: ☐ Individual Counselling Please specify for which client(s): …….. ☐ Couple Counselling Please specify for which client(s): …….. ☐ Sex Therapy Please specify for which client(s): …….

Section 4: Issues affecting the individual / couple		
	Past	**Current**
Parental drug/alcohol abuse		
Child drug/alcohol abuse		
Mental health issues adult/child		
Physical health issues adult/child		
Domestic violence – Physical/verbal/emotional		
Domestic violence – Controlling behaviour		

Sexual abuse		
Education issues		
Child behavioural issues		
Parenting skills		
Other (please specify)		

Section 5: Additional information	
Court proceedings: Please provide information about any current/pending/expected court proceedings	
Injunctions or legal orders: Please provide information about any current/pending/expected court injunctions or legal orders	
Child protection: Are any of the children on the Child Protection Register? Is there a CAF or a TAC in place?	
Other agencies: If there are any other agencies involved with the family please provide details.	
Special needs: Do any of the clients have special needs or disabilities?	
Language: Do any of the clients have language needs?	
Who should we contact to make appointments? Referrer / Client (please delete) Contact restrictions**:** Please tick all that apply. ☐ Ok to say Relate calling ☐ Ok to leave voicemail messages ☐ Ok to write to address	

☐ Do **not** to write to address

☐ Partner is **not** aware of contact

Funding:

Relate is a charity and has limited funds to provide services. The cost per session is **£55.00**, we would ask you to consider this cost and as an agency pay as much as you can to support your client in our service.

Number of sessions to be funded: …….

Any session which your client/s cancel at short notice (less than 48 hours) or fail to attend will be charge to the referring agency where funding has been agreed.

Referrers Name and Contact number: ……..

Invoicing to be sent to: (please provide full postal address along with e-mail address)

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When you have completed the form please return to info@relatecoventry.org