Counselling Referral Form

Please complete and return to your contact member of staff or enquiries@ycsa.org.uk

Referring Service / Agency

Name of Service / Agency	
Name of Worker	
Contact Number	
Date of Referral	

Client Details

Name:	
Date of Birth:	
Address:	
Telephone:	
Ethnicity:	

Areas of concern (Please tick all that apply)

Physical Health		Independent Living Skills	
Mental Health		Social Network/Family	
Learning		Activities/Community Involvement	
Work and Training		Attitudes/Behaviour	
Drug/Alcohol Misuse		Offending/Anti-Social Behaviour	

Reason(s) for Referral:

Emergency Contact Details:	
Surname:	Forename(s):
Title:	Preferred Name:
Contact address if different from above:	
Postcode:	
Home Telephone:	
Work Telephone:	
Personal Mobile:	Work Mobile:
Doctor's Contact Details:	
Surname:	Forename(s):
Surgery address:	
Postcode:	
Work Mobile:	
Surgery contact number:	

YCSA use only:
YCSA INTERNAL ASSESSMENT FORM COMPLETED YES☐ NO☐

Name of worker assigned	
Date of referral received	
Dates of attempted contact	
Method of contact	
Date of initial successful contact	

YOUTH COMMUNITY SUPPORT AGENCY