Counselling Self-Referral Form

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

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	

What do you feel you need support with?:

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	

COUNSELLING CLIENT CONTACT DETAILS

Please ensure all information is completed in full.

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:	