THURROCK CHILDREN'S CENTRES COUNSELLING SERVICE

REFERRAL FORM

Client name:	Client Address:	Client phone/mobile nos:
GP Details	**Referrer name, address/email**	**Referrer phone/mobile nos:**

Number and ages of children:	Will childcare be required?	How should client be contacted? (*e.g. are there any safety issues?)*
	Yes No (please circle)	

Reason for referral:			
Signed:		**Date:**	

Return completed referral to the Children's Centre where counselling is required – see addresses and emails on website page. Alternatively, the referral can be sent to the office:

Children's Centres Counselling Service
Thurrock Mind
152 Bridge Road
Grays
Essex
RM17 6DB

Email: reception@thurrockmind.org.uk

More copies of this form can be downloaded at: www.thurrockmind.org.uk