



Referral Form

This form is intended for use by health care professionals to refer clients to the Wiltshire Psychology Service

Name of client:

Date of Birth:

Address:

Telephone Number:

Email Address:

Referrer name:

Date of Birth:

Address:

Telephone Number:

Relationship to client:

Description of client's difficulties:

Reason for referral:

Risk issues:

Is the client currently receiving treatment from a mental health team Yes / No

Have they previously received treatment from a mental health team Yes / No

Has this referral been discussed with the client? Yes / No

Would the client like us to give you feedback on the outcome of this referral? Yes / No

Signed

Date