|  |  |
| --- | --- |
| If applicable:  Referring Organisation: | If applicable:  Referrers Name: |
| If applicable:  Referrers Contact Details: | Date of Referral: |
| Parent 1 Name:  Address:  Tel:  Email:  Employment: | Parent 2 Name:  Address:  Tel:  Email:  Employment: |
| Child details  Name:  Date of Birth:  School:  Living with: | |
| Reason for Referral: | |
| Days & Timings of when child could attend counselling appointments:  Any further information that may be relevant: | |

I give consent for the above information to be used in assessment of my child.

Sign……………………………………….. Date …………………………

Your completed form will be assessed by a qualified counsellor, who will contact you regarding the next step in our process of counselling provision.

Should you have any questions please feel free to get in touch either by email; [admin@lighthousecounselling.org](mailto:admin@lighthousecounselling.org) or telephone 01384 239222.

You can return the completed form via email to [admin@lighthousecounselling.org](mailto:admin@lighthousecounselling.org)

Post or deliver by hand to;

**The Lighthouse Centre**

**Lighthouse Counselling**

Salop Street,

Dudley,

DY1 3AT