

Counselling Service
Confidential

Reference No. CSL- _____ - ____

Counselling Referral Form

Date _____

Where did you hear about the service?

Referrer's Name: (i.e. Self-referral, Family, Social Services, Youth Organisation, G.P., Services Counselling Centres, etc.)

Name of Organisation: _____

Address:

Telephone: _____ Mobile: _____

Name of Client _____

Age: _____ Gender: _____ Ethnicity: _____

Address:

Contact Tele No: _____

30 Palace Road, 1 Barstow Crescent, Laburnum Court, Streatham Hill
London SW2 3NS.

TEL-0208 671 5843 Fax-0208 678 7844

Email: info@southlondonfamilycentre.org.uk

Website: www.southlondonfamilycentre.org.uk

Patrons: Baroness Howells of St David's OBE. Dr. John Roberts QC

*Community
Legal Service*



Occupation: (please tick as appropriate)

Employed Unemployed Student Other _____

Presenting Problems:

Please indicate any other issues you would like to add to this referral:

Please send completed form to the Counselling Service. Alternatively, you may leave a message for an appointment and we will get back to you as soon as possible.

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