BourneFamilyProject

REFERRAL FORM

Play Therapy ☐ **Adult Counselling** ☐

(Please tick service required)

Date of referral		**Referred by**	
Agency		**Contact Number**	
Address		**Postcode**	

Client Details

Name			
Address (inc Postcode)			
Telephone Number (Home)		**Mobile No**	
Email address		**Date of Birth**	
Family Members		**Relationship**	**Date of Birth**

ADULT COUNSELLING SESSIONS (If applicable)

Please state your availability for counselling sessions

Tuesday evening Yes/No **Friday am Yes/No**

Wednesday Yes/No

Is a daytime (Wednesday am only) crèche place required? Yes/No

Sessions are for 50 minutes

PLAY THERAPY (If applicable)

Please state your child's availability for sessions

Mondays Yes/No **Tuesdays Yes/No** **Wednesday Yes/No**

Preferred times 11am – 1pm 1pm – 3pm 3pm - 5pm

Sessions are for 50 minutes

REASON FOR REFERRAL

In which Council Area do you live? Bristol / South Gloucestershire / Other _____

What is your ethnicity? (optional)

(This information helps us with monitoring and funding applications)

I _____ (Print Name)

1 Agree to this referral being made to The Bourne Family Project and I have seen its contents.

2 Agree to The Bourne Family Project holding personal information about me on file in accordance with the data protection act.

3 Give my permission for members of staff from The Bourne Family Project to contact the agencies that I have indicated above on my behalf.

_____ (Signature) _____ (Date)

Thank you for taking the time to complete this form. Please forward it to:

Counselling Administration - bfp@bournechristiancentre.org

The Bourne Family Project
Bourne Chapel, Waters Road, Kingswood, Bristol BS15 8BE
Tel: 0117 947 8441 Fax: 0117 947 8316 E-mail: bfp@bournechristiancentre.org