UNDERSTANDING AUTISM North West

Referral to Counselling Service

This is not an emergency service

For urgent help please contact your doctor or go to A&E at the nearest hospital.

Please tick a box below to indicate who the counselling is for:
Individual ☐ Couple ☐ Family Member ☐ Parent & Child ☐
Name/s: Ref No: Office use only
Address:
Please complete preferred method/s of contact:
Home Phone: (can a voicemail be left? Yes/No)
Mobile: (can a voicemail be left? Yes/No)
Email:
Post to the above address?: Yes / No (please delete)
Date of birth: Age: Gender:
Diagnosis (if applicable):
Date of diagnosis:
G.P. Name:
G.P. Surgery Address:

Prefer us to make appointment arrangements through someone else? Please provide details:
Name: Relationship to you:
Phone:
If you have previously seen a UANW therapist and would prefer to see same person, please provide their name:

Please write any information you wish to add on the reverse of this sheet

Return this completed form to:

Understanding Autism NW, 25 Warner Street, Accrington. BB5 1HN

or email to: info@understandingautismnw.co.uk

Date Referral Received: Office use only