UNDERSTANDING AUTISM North West
Referral to Counselling Service

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:

Arrangements for the first appointment can be made through a family member. If this is preferred please provide details of the person to contact here:
Name:
Phone:
Relationship to client:

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

Please return this completed form to:
Understanding Autism NW,
25 Warner Street,
Accrington. BB5 1HN

Date Referral Received: (office use only)