ALIVE Wellness Centre - Referral Form

1. Basic Information:

- **Full Name of Client:**
- **Date of Birth:**
- **Gender:**
- **Preferred Contact Method:** ☐ Phone ☐ Email ☐ Other (Please specify)
- **Contact Information:**
    - Phone Number:
    - Email Address:

2. Referrer Details:

- **Referring Organisation/Individual:**
- **Referrer Name:**
- **Role/Position:**
- **Contact Information:**
    - Phone Number:
    - Email Address:

3. Reason for Referral:

- **Primary Reason for Referral:**
  (e.g., trauma support, resilience building, counselling needs, mental health support)
- **Brief Description of Client's Situation/Needs:**
  (e.g., recent exposure to trauma, ongoing support for resilience)
- **Specific Concerns or Goals for Referral:**
  (e.g., reduce isolation, improve coping skills, family engagement)

4. Preferred Support Type:

- ☐ Individual Counselling
- ☐ Group Support
- ☐ Family Support
- ☐ Physical Wellness Programmes (e.g., fitness activities)

- ☐ Peer Support Programmes
- ☐ Other (Please specify):

5. Urgency Level:

- ☐ Immediate (within 1 week)
- ☐ Moderate (within 1 month)
- ☐ Routine (no specific timeframe)

6. Additional Information:
(Any other relevant information that may help in offering appropriate support, such as language preferences or accessibility needs)

7. Consent:

- ☐ I confirm that the client has consented to this referral and is aware of ALIVE Wellness Centre's services.

Instructions for Submission: Please submit this form via email to laura.mace@alivewellnesscentre.orguk or through our secure online portal at alivewellnesscentre.org.uk. For questions, contact us at 0800 246 5298.