Date: ……../……../……..

Dear ……………………………………………………………

Service provider:.……………………………………………………………………………………………………

|  |  |  |  |
| --- | --- | --- | --- |
| Client name: |  | | |
| Gender: | Male / Female | Date of birth: |  |
| Address: |  | | |
| Contact numbers: | Business hours: | A message can be left: Yes / No | |
| After hours: | A message can be left: Yes / No | |
| Client’s preferred method and time to be contacted: |  | |

**Consent to share information gained from client: YES verbal / YES written / No**

This client contacted XXXXX service on ……………………….. by phone / in person / ……………….……

requesting………………….……………………………………………………………………………………………

……………………………………………………………………………………………………………………………

I have collected the following information about the client’s circumstances:

……………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………

Following a discussion with this client, we believe your service is best placed to meet their needs.

**The client has requested that you please phone them to follow up this request.**

**Urgency of request: Urgent / Routine**

The client has been given a copy of this referral: Yes / No

Please do not hesitate to contact me if you have any queries.

Yours sincerely,

**(Name of clinician)**

Role, Service

Phone: ………………………….…………….…….……. Fax: ………..…..…………………………………… Email: …………………………………………………………………….…………………………………………..