Date: ……../……../……..

Dear ……………………………………………………………..

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

|  |  |
| --- | --- |
| Client Name: |  |
| Gender:  | Male / Female | Date of Birth: |  |
| Address: |  |
| Contact Number/s: |  |

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

Your client completed their involvement with the ….XXXXXXXX… Program on (discharge date).

The following services have been engaged to assist with ongoing management:

|  |  |  |
| --- | --- | --- |
| **Agency** | **Contact Number** | **Services** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Ongoing issues that may require follow up are:

**……………………………………………………………………………………………………………………….**

**……………………………………………………………………………………………………………………….**

Other relevant information:

**………………………………………………………………………………………………………………………**

**………………………………………………………………………………………………………………………**

If you have any comments or questions, please do not hesitate to phone us.

Yours sincerely,

**Name of clinician**

Role, Service

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