

When the form is complete, please only email a scanned copy to eap@spectrum.life			
Name of employee:		Date:	
Organisation name		Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Job title of employee:		Employee's D.O.B:	
Tel no. where employee can be contacted:	Home:	Mobile:	
Location/address:		Postcode:	

Reason for referral:	
<p>Trauma response: Yes <input type="checkbox"/> No <input type="checkbox"/></p>	

Other relevant issues to be considered:	
<p>Is Employee off work Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, since when? _____</p> <p>Any previous counselling for this presenting issue? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when was this? _____</p> <p>Available days/times for counselling appointments:</p>	

Name & job title of Referrer:			
Address of referrer:		Postcode:	
Tel no:		Email:	
		FAX:	

Please sign below to confirm consent to make contact with the individual concerned. Should the individual not be available to sign, please make sure they have consented before sending referral:

Signed by Employee:.....

Date:

Signed by Referrer:.....

Date: