spectrum .life

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

| Reason for referral: | |
|---|---|
| | |

**Trauma response**: Yes ☐ No ☐

| Other relevant issues to be considered: | |
|---|---|
| | |

Is Employee off work Yes ☐ No ☐ If yes, since when? _____
Any previous counselling for this presenting issue? Yes ☐ No ☐ If yes, when was this?
Available days/times for counselling appointments:

| 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**: ……..