



**BHI COUNSELLING SERVICE (KU SIKIA) REFERRAL FORM**

*To be completed by the person making the referral / or the person requiring counselling.*

**REFERENCE NUMBER: ----- (Office Use Only)**

**DATE: -----**

**NAME: ----- D.O.B. -----**

**ADDRESS: -----**  
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**CONTACT NUMBER :**

**Message left Y /N**

**HOME No: -----**

**MOBILE: -----**

**SECOND EMERGENCY No: -----**

**RELATIONSHIP: -----**

**G.P. NAME: -----**

**ADDRESS: -----**

**TEL. No : -----**

**NAME OF REFERER: -----**

**ORGANISATION: -----**

**ADDRESS: -----**

**TEL: No: -----**

**REASON FOR REFERRAL: e. g .bereavement, relationship issues etc.**

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**RELEVANT BACKGROUND INFORMATION**

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**FORM COMPLETED BY:**

**NAME:**

**ROLE:**

**DATE:**

**Please return to:**

**BHI COUNSELLING SERVICE (KU SIKIA)  
BLACK HEALTH INITIATIVE  
231-235 CHAPELTOWN ROAD  
LEEDS  
LS7 3DX**

**TEL: 0113 3070300**

**THANK YOU**