



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: -----

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.

RELEVANT BACKGROUND INFORMATION

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