REFERRAL FORM

Date of Referral: ____ / ____ / ____

Client Information

First Name: _____ Date of Birth: _____

Last Name: _____ Age: _____

Telephone Number: _____ Gender: _____

Email Address: _____

_____

Home Address: _____

_____

City: _____ Postcode: _____

Reason for Referral

Please briefly describe your current situation and the reason for this referral:

_____

_____

_____

Previous Support / Therapy

Have you previously received therapy or support?

☐ Yes ☐ No

If yes, please provide the name of the therapist or service:

Please attach any discharge summary, referral notes, or report from previous service:

☐ Attached ☐ Not available

Referrer Information

Note: *To be completed only by professionals or authorised representatives referring a client. Individuals completing a self-referral may mark this section as "Not Applicable."*

Name of Referrer: _____

Role/Organisation: _____

Contact Telephone: _____

Contact Email: _____

Date: _____

Signature: _____

Submission Instructions

Please return the completed form (and any supporting documentation) via **email:** info@mlrumatter.org

If you have any questions about the referral process, please contact: info@mlrumatter.org

Privacy & Confidentiality Notice: *All information provided on this form will be treated as confidential and will be used solely for the purposes of assessment, planning, and provision of support services. By submitting this form, you confirm that you have obtained the client's consent for the referral and that they understand how their personal information will be used.*