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**When completed please upload this form and complete referral on service users behalf**

**Date of Assessment:**

**Referring Agency:**

**Name of person making the referral:**

**Address:**

**Telephone Number:**

**E-mail:**

**Do we have permission to contact the person being referred: Y N**

**Identified Risks:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Safeguarding |  | Mental Health |  | Physical Health |  |
| Violence & Aggression |  | Substance Misuse |  | Sex Offender |  |
| Learning Disabilities |  | Weapons |  |  |  |

**If any risks have been identified, please provide more details below:**

**Lone working risks (if appropriate):** *(please provide any information relevant to staff e.g. weapons, sexual offences etc)*

**Is the client aware that there is a fee for the counselling and anger management services and who would be responsible for paying any fees?**

**Client Referring Agency**