HOLDING SPACE REFERRAL FORM – ADULTS

Please complete and return this form via email contact@holdingspace.org.uk

NAME OF CLIENT	
GENDER	Male/Female/non binary/ prefer not to say
ADDRESS	
TELEPHONE NUMBER (Landline & mobile)	
DATE OF BIRTH	
AGE	
EMAIL ADDRESS	
NAME OF GP	
GP ADDRESS AND TELEPHONE NUMBER	
REASON FOR REFERRAL (please give brief background)	
IS CLIENT AWARE OF REFERRAL? WRITTEN OR VERBAL CONSENT	YES /NO WRITTEN/CONSENT Permission given to share personal information with Holding Space Yes/No
FAMILY NETWORK	
OTHER SUPPORT BEING RECEIVED? Please give details and names/contact details (CAMHs/ Social worker etc)	
NAME OF REFERRER	
RELATIONSHIP	
ORGANISATION/SCHOOL	
ADDRESS	
TELEPHONE NUMBER	
EMAIL ADDRESS	
SIGNATURE OF REFERRER	
DATE OF REFERRAL	

FOR HOLDING SPACE

DATE REFERRAL RECEIVED	
CONTACT MADE WITH CLIENT (date/ details)	
REFERRAL TO THERAPIST (name and date)	

Please return by email to: contact@holdingspace.org.uk

Data protection & Privacy: Holding Space will only use this data as part of the referral process and details will only be passed to members of Holding Space team of therapists. We will maintain your privacy and confidentiality in line with our privacy policy in accordance with GDPR. Copy of this available on our website or on request.