

Referral for Assessment

Please return to:

Cowal Council on Alcohol & Drugs, Ballochyle House, Kirk Street, Dunoon PA23 7DP
Tel/fax: 01369 704406 email: referrals@ballochylehouse.co.uk

Client Details

Name: _____ DOB: ____/____/____

Address: _____
_____ Postcode: _____ Letters y/n

Telephone: _____ Messages or answer machine y/n

Mobile: _____ Texts: y/n Voicemail: y/n

Preferred means of contact: _____

Reason for referral: _____

How client found out about Ballochyle House: _____

Which CCAD service are you most interested in (please tick only one)?

- Counselling Service Recovery Service
- Support Service Information Service
- Telephone Counselling, if you live outside Dunoon & its environs

Preferences for appointments and gender of worker or counsellor.

Appointments: morning / afternoon / evening / no preference

Gender of worker or counsellor: male / female / no preference

Client Signature: _____ Date: ____/____/____

Referrer Details [or tick this box if self referral

Name: _____ Organisation: _____

Address: _____ Postcode _____

Telephone/Mobile: _____

Email: _____ Date: ____/____/____

Referral acknowledged by letter/email/phone/text/in person Initials: ____ Date: ____/____/____
(delete as necessary)