



CONFIDENTIAL INFORMATION

Name:	
Date of Birth (dob)	
Title: (please circle)	Prof. Dr. Mr. Mrs. Miss. Mz.
Address:	
Postcode:	
Tel: Home	
Work	
Mobile	
Can we leave a message?	Yes/No
Email:	
What type of therapy/service? (please circle)	CBT /EMDR CISD Initial Assessment CBT (2 hours) Debt Counselling Psychological Assessment Psychiatric Assessment Coaching
Who referred you to us? (please circle)	Self – GP – Company – Consultant - School- Social Services Friend
Company/Surgery/Hospital etc. Name: (please leave blank if not applicable)	
Address and Contact details:	
Tel:	
Email:	
Presenting Problem	Anxiety, Anger, Bereavement, B & H, Depression
Can you give me a brief description of your problem? (please circle)	Drug & Alcohol, Work Grievance, OCD Personal, Relationship, Stress, PTSD, Eating Disorder
Work status	At work Off sick Rehab/Light duties Suspended

Data Protection and Client Responsibility

The Client is aware that medical information will be kept confidential and will only be disclosed to those involved with the clients treatment or care, and if applicable to any person or organisation who may be responsible for meeting their treatment expenses. Also that in the event of them not being able to attend a pre-arranged session, they must provide 48 hours notice of cancellation or the missed session will be allocated against their contractual number of sessions. (Please tick only if you have done this)

Referral authorised by:
(Name/Signature)

Date:

Fax back to: 01206 814 741 or Email: referrals@saunders-clinic.co.uk

Thank you

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Payment details

Insurers name:
Address:
Tele:
Client membership number:
Authorisation number:

Card payment: (Company and Individuals)

Please complete details below – Thank you



Name: _____

Card Details
Card Type:(Please circle card type)

VISA, MASTERCARD, SOLO, JCB, VISA Electron, AMERICAN EXPRESS

Name on Card: _____

Card Number: _____

Valid From: _____

Expiry Date: _____

Security No from (Signature strip) _____

Signature: _____

Date: _____

Company Payment Invoice:

Contact Name: _____

Address: _____

Tel: _____

Fax: _____

Email: _____