|  |  |
| --- | --- |
| A close up of a logo  Description automatically generated | **CUBE**Support Assessment & Referral form |
| Client Ref No. |  | Date |  | CUBE Project |  |
| Client Name |  |  Age |  | Gender |  |
| Address and Telephone Number  |  |
| Is the client receiving any other support at the moment? |   |
| Has the client had counselling or therapy before? |   |
| If yes who  |  | For how long |  |
| Was it helpful  |  |
| Name of GP |  | Surgery |  |
| Details of medication and/or substance use: |
| Other Agencies Involved: |
| Brief description of current issues: |
| What is the client hoping to achieve from support with CUBE: |
| Anything other information you feel may help: |
| Availability of client | Any Time | Yes / No |
|  | Monday | Tuesday | Wednesday | Thursday | Friday |
| Morning |  |  |  |  |  |
| Afternoon |  |  |  |  |  |
| Evening |  |  |  |  |  |
| Has the support contract been agreed |   | (Contract will be discussed at first meeting) |
| Are there any Specific Needs |   | If yes, please specify: |
| Referred by |  | Authorised |  | Date |  |