

Counselling and Therapeutic Service Referral Form 2013

Name:				
Address:				
Postcode:				
Is it ok to contact you at this add	dress? Yes □ No			
Contact Telephone Number				
Home No: Email:	or Mob	ile No:		
Date of Birth:	Gender	Ethnicity		
Age:		Is an Interpreter Required?	Yes □ No □	
Who do you live with?				
Name, Agency and Contact number of person making the referral: Date of Referral:				
Is this referral made with your full agreement? Yes No				
Are your Parents/Guardian aware of this referral? Yes □ No □				
Are you In Care/Care Leaver? Yes □ No □				
Have you seen a counsellor before? Yes □ No □ If yes, who and how long ago?				
Do you have a Doctor? If 'Yes' please give the name and address and telephone number if possible:				

Do you have any medical conditions that we need to	know about? If yes please specify.		
How do you cope when you are stressed or things are	e going wrong?		
Are you taking any prescribed medication that we need if 'Yes' please give details:	ed to know about? Yes □ No □		
Are you receiving support from any other professional	l? Yes □ No □		
If 'Yes' please tick the ones which apply: Psychologist Consultant/Medical Specialist Counsellor Dietician Other (please specify)	Nurse CPN (Community Psychiatric Nurse) Psychiatrist Social Worker		
Who is there to support you in terms of family or friends?			
Do you have a learning difficulty or disability? If 'Yes' please give details	Yes □ No □		
Is there a reason why you would have a preference for a male or female counsellor?			
Please make us aware of any issue that could affect availability e.g. school, work, training etc			
Please tell us briefly what issues or feelings are worry about with the counsellor.	ing you at the moment that you would like to talk		