

COUNSELLING SERVICE REFERRAL FORM NEWARK

Details Of Referrer			
Name Of Referrer			Position
Self Referral (if so, please go indicate yes and go straight to section 2 of	Yes		No
Date Of Referral			
Referring Agency			
Contact Address	Preferred method of contact:		
Contact Number(s)			
Email Address			

(Section 2) Persons Details			
Name			
DOB/Age			
Address			Post Code
Contact Number(s)			
Can a message be left?	Yes		No
GP Details			
Health Issues/ Medication Taken			
Disability: If Yes Please State			

Has the client accessed Counselling before?			
Who With?			
What type of Counselling?			
How long ago?			
Risk Self Harm? Harm to others Drugs Alcohol	Yes		No
Additional Agency Involvement/Therapeutic Relationships			
Please indicate whether you are currently involved with any other organisation (e.g. School, Social Services and CAMHS etc). Including any current counselling/therapy relationships.			
Agency	Contact Name & Number		

Reason For Referral/Presenting Issues (Please briefly explain your reasons for wishing to seek help from our counselling service)
<p>Please note; All of our Counsellors and staff are bound to confidentiality and adhere to the Data Protection Act 1998. However, should you disclose any information that relates to yourself or somebody else being In immediate danger, they are obligated to inform relevant organisations or individuals.</p>

Client's Aims For Counselling?
(What Do You Wish To Gain From Accessing Counselling?)

Signed		Print		Date	
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Please mark below by ticking **all** times when you are available for an initial appointment.

Monday		Tuesday		Wednesday		Thursday		Friday	
AM		AM		AM		AM		AM	
PM		PM		PM		PM			

Please confirm that we can contact you via the following :

Text Email Phone Post

Your data will be sorted in line with the new GDPR guidelines and Minds policies and procedures.

OFFICE USE ONLY

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Please return this form by email to:

referrals@centralnottsmind.org

Central Notts Mind,
14 St Johns Centre,
Mansfield,
Nott's,
NG18 1QJ

01623 658044