**REFERRAL FORM: The FORD Counselling and Psychotherapy Centre.**

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| **DETAILS OF PERSON BEING REFERRED** |
| **NAME:** | **DATE OF BIRTH** |
| **ADDRESS** |
| **GENDER MALE ( )** |  **FEMALE ( )** |
| **TELEPHONE NUMBER:****MOBILE NUMBER:** | **CLIENTS CAN BE CONTACTED BY****LANDLINE: ( ) MOBILE: ( ) LETTER: ( )****[Please tick ( ) as appropriate** |
| **DOES PERSON HAVE ADDITIONAL NEEDS?****(E.G. REQUIRE WHEELCHAIR ACCESS, Interpreter etc.)** |
| **REFERRER DETAILS** |
| **NAME OF REFERRAL AGENT:** |  |
| **ADDRESS FOR REFERRING AGENT:** |
| **TELEPHONE NUMBER@** | **MOBILE NUMBER:** |
| **SIGNATURE;** | **JOB TITLE:** |
| **MEDICAL HISTORY OF PERSON BEING REFERRED** |
| **Please give details of any relevant medical history.** |
| **Please give details of any current medication** |
| **Please give details of any relevant mental health history, including current / past attendances at mental health services or other counselling or addiction services.** |
| **REASONS FOR REFERRAL** |
| **Please give specific details of the main symptoms / presenting difficulties including duration / degree of impact on day to day functioning and any additional difficulties the person referred is currently experiencing:** |
| **Is there any other information about the person or their difficulty that you would consider relevant?** |
| **THE CLIENT NEEDS TO OPT IN TO** **The FORD Counselling and Psychotherapy Centre** **BY** **CONTACTING 053-9123086** |
| **NOTE:** **1. The FORD Counselling and Psychotherapy Centre PRIORITISES CLIENTS WHO ARE NOT IN RECEIPT OF MEDICAL CARDS BUT WHO CANNOT AFFORD PRIVATE COUNSELLING SERVICES.****2. The FORD Counselling and Psychotherapy Centre DOES NOT WORK WITH CLIENTS WHO ARE IN ACTIVE ADDICTION** |
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| **PLEASE RETURN COMPLETED FORM TO :****The FORD Counselling and Psychotherapy Centre** **12 ROCHES’S ROAD****WEXFORD** **OPT IN NUMBER FOR CLIENTS: 053 9123086****Please ask clients to call the above number to OPT IN within 2 weeks.** |