**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.** | |