Mabadiliko Therapy Ltd
Change Renews the Mind

ADULT THERAPY REFERRAL FORM
CONFIDENTIAL

The information supplied on this form is only handled by registered data controllers for GDPR compliance. Please complete all fields in the following form and email it back to admin@mabadilikotherapy.com

First name:	
Surname:	
Your email:	
Main contact number:	
Is it alright to leave a message?	
London Postcode (FIRST PART ONLY) or Region (If outside of London)	
Age and Gender	
Disability or learning difficulty:	
Children: **Age/s:**	
Employment status:	
Occupation:	
Are you a carer / Do you support someone that has extra care needs?	
How would you describe your ethnic / cultural background?	
Religion / Spiritual beliefs including influences from upbringing:	
How did you find out about Mabadiliko Therapy Ltd ?	

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Have you had therapy/counselling before?	
Please briefly describe the reason for seeking therapy at this time:	
Do you have any mental health diagnosis or undiagnosed concerns? Please include the name and dosage of any mental health medication you have been prescribed.	
Please specify particular days you are most available for ongoing therapy sessions:	
Please specify your time preference for therapy sessions (morning, afternoon and/or evening)	
Please specify if you have any preferences for the therapist that might work with you:	
E-Signed:	
Date:	

Thank you for completing all fields above, your completed form will be used during the consultation.

The consultation is an opportunity to establish your therapeutic needs and assess suitability to the service. After the consultation you may be allocated to an associate therapist, therefore the person conducting your consultation might not be your on-going therapist. Your consultation will be booked in for the earliest mutual available appointment which might differ from the day and time of your on-going therapy sessions.

If you have any questions please feel free to get in touch either by email admin@mabadilikotherapy.com or telephone/WhatsApp: 07708845550 (Please leave a clear message if you get no answer, and your call will be returned)

Please proceed to the well-being questionnaire (CORE 10) below and complete the answers as indicated.

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Clinical Outcomes in Routine Evaluation (CORE 10)

This form has 10 statements about how you have been **OVER THE LAST WEEK**. Please read each statement and then mark each box which is closest to the way you have been feeling with X.

		Not at all	Occasionally	Sometimes	often	Most or all of the time
1	I have felt tense, anxious or nervous	0	1	2	3	4
2	I have felt I have someone to turn to for support when needed	4	3	2	1	0
3	I have felt able to cope when things go wrong	4	3	2	1	0
4	Talking to people has felt too much for me	0	1	2	3	4
5	I have felt panic or terror	0	1	2	3	4
6	I have made plans to end my life	0	1	2	3	4
7	I have had difficulty getting to sleep or staying asleep	0	1	2	3	4
8	I have felt despairing or hopeless	0	1	2	3	4
9	I have felt unhappy	0	1	2	3	4
10	Unwanted images or memories have been distressing me	0	1	2	3	4
	TOTAL =					

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Adapted from CORE System Trust: https://www.coresystemtrust.org.uk

Company Registration Number
11827715

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FOR OFFICE USE ONLY

TO BE COMPLETED DURING CONSULTATION

DATE	
AVAILABILITY	
AGREED FEE	
FREQUENCY	
DURATION	
PHYSICAL HEALTH CONCERNS	
MEDICATION	
CURRENT SITUATION	
GENOGRAM/FAMILY DYNAMIC	
HISTORY	
EXPECTATIONS/GOAL ACHIEVEMENT	
ADDITIONAL INFORMATION	
SCREENING	
ASSESSOR COMMENTS	