**Referral Form**

* To be completed by either:
  + The external referrer , i.e. GP, counsellor or
  + The client if it is a self-referral

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| --- | --- | --- | --- |
| **\* Date of Referral:** |  | **Referring Clinician:** |  |
| **\*Client Name:** |  | **Agency Name:** |  |
| **\*Date of Birth:** |  | **Referring Clinician Contact number:** |  |
| **NHI Number:** |  | **Referring Clinician email:** |  |
| **Address:** |  | **GP Name:** |  |
| **\*Phone Numbers:** |  | **GP Practice:** |  |
| **Email:** |  | **GP Contact Number:** |  |
| **\*Preferred contact time and method:**  **Consent to leave a voicemail** |  | **Client Ethnicity/Relevant Cultural Information:** |  |

**Confidentiality**

*Has the client explained confidentiality and the limit of confidentiality?*

**Informed consent**

*Has the client given their consent to have their information shared with their referee/ GP?*

**Referral Information**

* **To be completed by either (1) the client or (2) external referrer**

**Informed consent – check this has been covered on the referral form (page 1)** [ ]

**Reason for the referral**

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| *What are the main psychological issues? E.g, client is not sleeping, experiencing anxiety/low mood, has had a change of life circumstances* |

**Safety Concerns**

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| *Are you or the client concerned about their safety?*  *Is the client suicidal or at risk of harming themselves or someone else (including drink/drug driving, self-injurious behaviour)?*  *If Yes please describe why below* |

**Past and Current Intervention**

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| --- |
| *Is the client receiving any current intervention, i.e. medication? If yes, what medication and dosage? If not, has the client received any intervention in the past? What other services are involved?* |