

**REFERRAL FORM**

Date of Referral: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Client Information

First name:  Last name:

Date of Birth:  Gender

Telephone number:

Email address:

Home address:

City:

Postcode:

GP address:

Mediation:

Please tell us briefly about the reason for seeking therapy, and any previous psychological treatment.

Have you previously received therapy? ☐ YES ☐ NO

If yes, can you please state with whom (NHS/Private) \_\_\_\_\_

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Can you please also send the discharge letter from the previous therapist, alongside this referral form.

What is your native language?

What language would you like to have sessions in?

Signed: \_\_\_\_\_

Date:

You can return the completed form by email to: [info@mira.community](mailto:info@mira.community)