# Stress Project Therapies - Referral Form

Please indicate which service:

**In-Person Counselling**

12 to 26 weeks

## Please Note

* **A referral is required which must be completed by a GP, other health care professional or support worker**
* **Cost: Low-cost counselling from £12 is available for people living in Islington.**
* **All sections of this form must be completed.**
* **Initial assessment will be arranged within 2 weeks of receiving the referral.**

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## The service is not suitable for any of the following:

 **Severely disturbed or psychotic.**

** Where short-term support would be counter productive.**

** Chaotic drink or drug use.**

** Severe eating disorder.**

** Severe learning difficulties.**

** Agoraphobic and unable to commit to weekly sessions.**

** Violent/severely aggressive behaviour.**

** Severe paranoia.**

1. **Date of Referral:** Click or tap here to enter text.
2. **Client Details:**

Name: Click or tap here to enter text.

Address: Click or tap here to enter text. Postcode: Click or tap here to enter text.

Date of birth: Click or tap here to enter text. Telephone Number: Click or tap here to enter text.

Email: Click or tap here to enter text.

Is the Client a resident of the London Borough of Islington Yes  No

Gender:Female  Male  Non-Binary  Prefer not to say

Does the client have a disability?:Yes  No  Prefer not to say

Ethnicity:

Black UK  Black African

Black Caribbean  Any other Black background

White UK  White Irish

Gypsy or Irish Traveller  Any other White background

Asian UK  Asian Indian

Asian Pakistani  Asian Bangladeshi

Asian Chinese  Any other Asian background

Mixed Ethnic Background  Arab

Other

## Referrer’s Details

Name: Click or tap here to enter text. Position: Click or tap here to enter text.

Organisation: Click or tap here to enter text.

Address: Click or tap here to enter text. Postcode: Click or tap here to enter text. Telephone: Click or tap here to enter text. Email: Click or tap here to enter text.

#### Further Information - Please indicate all that are relevant:

Has been in residential psychiatric care in the last 12 months

Has been in residential psychiatric care more than once

Is at serious risk of entry or re-entry into residential psychiatric care

Has the client ever been sectioned under the mental health act?

#### Symptoms & Situations - Please indicate all that are relevant:

Sleeplessness  Panic attacks

Irritability  Paranoia

Depression  Anxiety

Low Energy  Mood swings

Physical/sexual abuse in childhood  Lives unsupported on their own

Physical/sexual abuse in adulthood  Family breakdown

Single parent  Bereavement

Attempted suicide or suicide risk  Past history of drug/alcohol abuse

1. **Current Treatment**

Medication: Click or tap here to enter text.

Other Medical Treatment: Click or tap here to enter text.

Counselling/Psychology Service: Click or tap here to enter text.

Please Provide Further Details of Psychiatric, Medical and Social History:

Click or tap here to enter text.

GP’s Contact Details (Unless Referrer): Click or tap here to enter text.

Names & Contact Details of Any Agencies/Individuals Involved in The Care of the Client:

Click or tap here to enter text.

Any Other Relevant Information: Click or tap here to enter text.

Please return this form to [stressproject@hng.org.uk](mailto:stressproject@hng.org.uk)

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