# Low-Cost Therapy Programme - Referral Form

Please indicate which service:

 [ ]  **In-Person Counselling** [ ]  **Online Counselling** [ ]  **Acupuncture**

12 to 26 weeks 12 to 26 weeks 8 weeks

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Please Note* **A referral is required which must be completed by a health or social care professional**
* **Cost: £12 to £45 depending on income.**
* **All sections of this form must be completed.**
* **Initial assessment will be arranged within 2 weeks of receiving the referral.**
 |  |  |  |  |  |  |  |

## 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.

## 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

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