# Online and Telephone Counselling Referral Form

Please indicate which service:

|  |  |
| --- | --- |
| **Online Counselling**  1 hour per week - up to 26 weeks | **Telephone Counselling**  1 hour per week – up to 26 weeks |
| Please Note  * **A referral is required which must be completed by a health or social care professional** * **Cost: £12 to £65 depending on income.** * **All sections of this form must be completed.** |  |

## 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](mailto:stressproject@hng.org.uk)

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