Counselling Support Service Referral Form

Counselling provides a professional therapeutic service to families using the Northern Ireland and England only.

Who is the counselling for

Name: ..... DOB: ..... Gender: M ☐ F ☐

Address: ..... Age: ..... Non-binary ☐

..... Tel No: ..... *(Mobile)*

Postcode: ..... Tel No: ..... *(Home)*

Name of Parent/Guardian (if<16 yrs): *Can a message be left? Yes / No please circle*

Emergency Contact/Next of Kin: ..... Relationship to you:.....

Address: .....

..... Tel No: .....

Postcode: ..... *Can a message be left?* Yes / No *Please circle*

Medical Information

GP Name: ..... Medical Condition (s) .....

Address: ....

..... Postcode:..... Current Medication (s) .....

Surgery Name: ....

Reason for referral *(please tick the relevant boxes below)*

Reason(s) for Counselling Request:

Brain Injury Related	
Parent / Carer	
Other *(please state)*	

Referring to:

Adult Counselling (18+)	
Youth Counselling (11 - 17)	

Please expand on the area(s) ticked above, providing brief details:

.....

.....

.....

Additional Reason(s): *if applicable*

Stress		Anger		Low Mood / Depression	
Bullying/Intimidation		Anxiety		Self Esteem	
Suicidal Thoughts		Self Harm		Relationship Difficulties	
Personal/Family Illness		Sleeping Difficulties		Other *(please state)*	

Other (please state).....

What issues do you feel counselling might be able to help with? *(please tick the relevant boxes below)*

Communicating:

Relating to people one-to-one	
Relating to people in a group	
Help talking about feelings	

Confidence:

Self-esteem	
Confidence in a group	
Feelings of powerlessness	

Low Mood:

Building motivation	
Help with feelings of despair	

Anxiety:

Developing relaxation skills	
Managing stress	

What would be a good outcome for you? Any questions or queries?

.....

.....

.....

.....

.....

.....

Availability *(please tick the relevant boxes below)*

When would you like counselling to begin? .....

When are you available for counselling? *please tick all availability*

Monday Evening		Friday Evening	
Tuesday Evening		Saturday Morning	
Wednesday Evening		Saturday Afternoon	
Thursday Evening		Other *(please state)*	

Please state available times: .....

Previous Experience, Contact and Consent

Have you previously attended counselling? Yes / No *(please circle -* ***if yes, please provide further details*** *)*

Timeframe *(from-to):* ..... Organisation(s): .....

Number of sessions: ..... Was it helpful? Yes/No *(if no, why not?)*

.....

Are there any other relevant services currently supporting the client (you) that we may contact? *Please detail below*

Agency: .....

Contact Name: .....

Address: .....

Tel No: .....

Notes: .....

.....

Agency: .....

Contact Name: .....

Address: .....

Tel No: .....

Notes: .....

.....

RISK: Are there any current risks we should be aware of? Yes / No *(please circle)*

If yes, please detail below including any prior and/or current risk management plans / involvement of other agencies (eg: Social Services)

.....

.....

.....

I give permission for the counsellor to contact 3rd parties such as my GP/Next of Kin (if appropriate) | | *please tick*

Client Signature: ..... **Date: .....**

Parent/Carer Signature: ..... **Date: .....**

Referrer Details

Name: .....

Org: .....

Address: .....

..... Postcode: .....

Tel No: .....

Email: .....

Source of Referral *(please tick)*

Health Professional		**Statutory Agency**	
Counselling Agency		**Client Themselves**	
GP		**Family Member**	
Community Org.		**Parent / Guardian**	

Referrer Signature: ..... **Date: .....**

Please return this form to info@cbituk.org

or post to: Child Brain Injury Trust, Unit 1 Great Barn, Baynards Green Farm, Baynards Green, Nr Bicester, Oxfordshire, OX27 7SG

For Office Use

Client Code:		NI Trust Region of client:	
Project Code:	Early Years.....Primary.....Transitional.....	England Location	