Counselling Support Service Referral Form

Counselling provides a professional therapeutic service to UK wide families receiving our support.

Who is the counselling for:						
Name:		Gender:	Male ☐	Female ☐	Non-binary ☐	
Address:		Age:				
		DOB:				
		Tel No *(Mobile)*:				
Postcode:		Tel No *(Home)*:				

Next of kin:				
Name of Parent/Guardian *(if < 16 yrs):*		Can a message be left?	Yes ☐	No ☐
Emergency Contact/Next of Kin:		Can a message be left?	Yes ☐	No ☐
Relationship to you:				
Address:				
Postcode:				

Medical Information:			
GP Name:		Medical Condition(s):	
Surgery Name:			
Address:		Current medication(s):	
Postcode:			

Reason for referral *(please tick the relevant boxes below):*			
Reason(s) for Counselling Request:		Referring to:	
Brain Injury Related	☐	Adult Counselling *(18+)*	☐
Parent/Carer of young person with an ABI	☐	Youth Counselling (11-17)	☐
Sibling of a young Person with an ABI	☐		
Other *(please state)*	☐		

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:		Confidence:	
Relating to people one-to-one	☐	Self Esteem	☐
Relating to people in a group	☐	Confidence in a group	☐
Help talking about feelings	☐	Feelings of powerlessness	☐
Low Mood:		Anxiety:	
Building motivation	☐	Developing relaxation skills	☐
Help with feelings of despair	☐	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 ☐	
If yes, please provide further details:					
Timeframe		Organisation:			
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:					
Telephone Number:					
Notes:					
Agency:					
Contact Name:					
Address:					
Telephone Number:					
Notes:					

Risk:		
Are there any current risks we should be aware of?	Yes ☐	No ☐
If yes, please detail below including any prior and/or current risk management plans/involvement of other agencies *(eg: social services):*		

Referrer Details:					
Name:		Source of Referral:			
Organisation:		Health Professional	☐	Statutory Agent	☐
Address:		Counselling Agency	☐	Client Themselves	☐
Postcode:		GP	☐	Family Member	☐
Telephone Number:		Community Organisation	☐	Parent/Guardian	☐
Email:					
Referrer Signature:		Date:			

Please return this form to info@cbituk.org
Post to: Child Brain Injury Trust, Field View, Baynards Green Trading Estate, Baynards Green, Nr Bicester, Oxfordshire OX27 7SR

For Office Use			
Client Code:		NI Trust Region of client:	
Project Code:		England Location:	