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 | | | |  | | --- | |  | | | |
| Tel No: | | |  | | | | | | |  | | | |  | | |  | | |  | | |
| Emergency Contact/Next of Kin: | | |  | | | | | | | Can a message be left? | | | | | | | | | | | | Yes | | | | |  | | --- | |  | | | | No | | | |  | | --- | |  | | | |
| Tel 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](mailto:info@cbituk.org)

Post to: Child Brain Injury Trust, Field View, Baynards Green Trading Estate, Baynards Green, Nr Bicester, Oxfordshire OX27 7SR

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