Counselling Support Service Referral Form

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

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| **Who is the counselling for:** |
| Name: |  | Gender:  | Male |

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 | Female |

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 | Non-binary |

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| 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 |

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 | No |

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| Tel No: |  |  |  |  |  |
| Emergency Contact/Next of Kin: |  | Can a message be left? | Yes |

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 | No |

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| 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 |

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 | Adult Counselling *(18+)* |

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| Parent/Carer of young person with an ABI |

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 | Youth Counselling (11-17) |

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| Sibling of a young Person with an ABI |

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| Other *(please state)* |

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| Please expand on the area(s) ticked above, providing brief details: |
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| Additional Reason(s): (if applicable) |
| Stress |

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 | Anger |

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 | Low Mood/Depression |

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| Bullying/Intimidation |

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 | Anxiety |

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 | Self Esteem |

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| Suicidal Thoughts |

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 | Self-Harm |

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 | Relationship Difficulties |

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| Personal/Family Illness |

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 | Sleeping Difficulties |

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 | Other (please state) |

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| Other (please state): |
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| **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 |

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 | Self Esteem |

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| Relating to people in a group |

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 | Confidence in a group |

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| Help talking about feelings |

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 | Feelings of powerlessness |

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| Low Mood: | Anxiety: |
| Building motivation |

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 | Developing relaxation skills |

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| Help with feelings of despair |

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 | Managing stress |

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

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 | Friday Evening  |

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| Tuesday Evening |

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 | Saturday Morning |

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| Wednesday Evening |

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 | Saturday Afternoon |

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| Thursday Evening |

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 | Other (please state) |

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| Please state available times: |  |
| **Previous Experience, Contact and Consent:** |
| Have you previously attended counselling?  | Yes |

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 | No |

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| If yes, please provide further details: |  |
| Timeframe |  | Organisation: |  |
| Number of sessions |  | Was it helpful? | Yes |

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 | No |

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| 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 |

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 | No |

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| If yes, please detail below including any prior and/or current risk management plans/involvement of other agencies *(eg: social services):* |
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| **Referrer Details:** |
| Name: |  | Source of Referral: |
| Organisation: |  | Health Professional |

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 | Statutory Agent |

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| Address: |  | Counselling Agency |

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 | Client Themselves |

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| Postcode: |  | GP |

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 | Family Member |

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| Telephone Number: |  | Community Organisation |

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 | Parent/Guardian |

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| 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

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