

**THERAPY REFERRAL FORM**

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| OFFICE USE ONLY |
| Date received: | Case ID: |

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| REFERRING AGENCY DETAILS |
| Name of referrer: |  |
| Position: |  |
| Organisation: |  |
| Telephone: |  |
| Email: |  |

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| CLIENT DETAILS AND INFORMATION |
| First name: |  | Forename: |  |  |  |
| Also known as: |  | Male: |  | Female: |  |
| Date of birth: |  | Telephone: |  |  |  |
| Address: |  | Parent ECAF No. (If applicable) |  |
| Postcode: |  | Email address: |  |  |  |
| Best time to contact client: | Morning Afternoon Evening  |
| Best method of contact: | Phone call Text message Email address Letter  |

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| CLIENTS ETHNICITY (please tick) |
| White | Mixed |  | Asian or Asian British | Black or Black British | Other Ethnic Groups |
| British  |  | White/Black Caribbean |  | Indian |  | Caribbean |  | Chinese |  |
| Irish |  | White/Black African |  | Pakistani |  | African |  | Any other ethnic group (please specify below) |
| European |  | White/Asian |  | Bangladeshi |  | Any other background (Please specify below) |
| Any other White background (Please specify below) |  | Any other White background (Please specify below) |  | Any other Asian background (Please specify below) |  | Not stated |  |
|  | Religion: |

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| REASON FOR REFERRAL (please tick all that apply) |
| Anxiety (worry) |  | Physical and emotional health issues |  |
| Bereavement, grief, and loss |  | Personality disorder |  |
| Caring responsibilities |  | Pre-postnatal depression |  |
| Childhood trauma |  | Post-Traumatic Stress Disorder (PTSD) |  |
| Depression |  | Relationship breakdown (separation / divorce |  |
| Eating disorder |  | Self-harm |  |
| Emotional / physical abuse |  | Suicidal thoughts |  |
| Low self-esteem / confidence |  | Other |  |

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| REASON FOR REFERRAL (details) |
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| OTHER KEY AGENCIES INVOLVED |
| Agency / Support Worker | Please tick: | Agency / Support Type: | Please tick: |
| Health Visitor / Family Support Worker |  | Probation |  |
| Housing Team |  | Police / Her Majesty’s Prison Service |  |
| College / Education Pastoral Team |  | Local Charity |  |
| Mental Health Team |  | Support Group |  |
| Adult Social Care / Social Worker |  | Other |  |

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| CLIENT SUITABILITY |
| Beyond Blue Counselling Services has been developed by Breakthru Community Interest Company a charitable organisation. Beyond Blue offers both free and chargeable sessions, based upon the individuals’ circumstances. Clients will be offered 6 x 50-minute sessions but may wish to engage in other services we provide.Chargeable sessions are charged at a standard rate. It’s our good practice that all our therapists follow the **British Association of Counselling and Psychotherapy** (BACP), or the **National Counselling Services** ethical framework for counselling professions.As an organisational member of the BACP Breakthru’s ethics are based on values and principles and personal moral qualities that underpin and inform the interpretations and application of **Our Commitment to Clients** **and Good Practice**.All our therapists are DBS checked, professionally qualified, have the appropriate insurance, and accredited by relevant professional bodies. They will work with **YOU** to meet **YOUR** goals. |
| The client is happy to be assessed prior to any counselling sessions taking place? | Yes  | No  |
| The client understands that they need to be willing to engage and be ready to move towards change? | Yes  | No  |
| The client understands that they need to attend 6 sessions as part of their therapy? | Yes  | No  |
| The client is aware that we the counsellor will discuss past trauma to address issues to support them to move forward? | Yes  | No  |

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| DATA PROTECTION – Handling personal information |
| The personal information you provide will be used for the purposes of Breakthru – Beyond Blue Counselling Services. The information provided may be shared with Adult Social Care, NHS, GP’s, Counselling Services, and funding organisations. However, no names or addresses will be shared.For the purposes of the GDPR and the Data Protection Act 2018, Breakthru is the data controllers in respect of information processed which relates to this referral and a client’s participation in Beyond Blue’s Counselling Service. Information provided on this form will be entered and stored onto a secure database used for the purposes of Breakthru. A client’s personal information will not be used for any other purpose than stated. Additional consent form will be obtained. Further information on how data is held, can be obtained by contacting the Director of Breakthru. |
| To evaluate our programme. We would like each client to complete an anonymous questionnaire once the sessions are complete. This allows Breakthru to continually offer the best services our clients need, through feedback. If they do not wish to be contacted, please indicate: | Yes  | No  |

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| REFERRER SIGNATURE |  |
| (Please print referrer’s name if sent electronically) |  |
| Client’s signature (if client is present when the referral is made) |  |
| *Please return to* ***info@break-thru.co.uk*** |