CARE COMMUNITY COUNSELLING CENTRE

REFERRAL FORM

Your Name:	Date of Birth:
Your Address:	
Telephone numbers you can be contacted on:	
Name & address of your GP practice:	GP's name & telephone no:

Please answer the following questions to help us think about how best to help you.

(Please attach a separate page if you need more space.)

1. What are the main problems that have led you to ask for help? (e.g. low mood, panic attacks, shyness, worrying, bereavement, etc.)

2. How long have you had these problems? (e.g. weeks, months, years?)

3. Are you currently seeing anyone for counselling / psychotherapy, drug or alcohol problems, or for any other mental health support? ☐**Yes** ☐**No**

If **Yes**, please give details of where and for how long you are seeing them.

4. Do you have any medical problems or are you on any medication at the moment? ☐**Yes** ☐**No**

If **Yes**, please give details:

5. In the **past 2 weeks** have you had any thoughts that you would be better off dead or of hurting yourself in some way? ☐**Yes** ☐**No**

6. Is there anything else that you think it is important for us to know about?

Signature: _____ Today's date:_____

OFFICE USE ONLY

Date Received:	Attempted Contacts:	Tel contact made:	Appointment made: