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| **Referrer Consent** (*to be completed by referrer)* |
| Name: |  | Preferred name: |  |
| Gender: |  | Date of Birth: |  |
| GP Practice: |  | Age: |  |
| Emergency: Contact |  | Referral Date: |  |
| Is this your 1st referral to us? | YES NO | Phone: |  |
| Do you have any access requirements? |  | Email: |  |
| **Relevant medical and personal information**  |
| Reason(s) for counselling (mark with an ‘X’ as many boxes as apply): |
| 1. Reduce stress / anxiety / depression |  | 5. Work related issue or upset |  |
| 2. Recovery from anxiety resulting from pandemic |  | 6. Suicidal thoughts or feelings |  |
| 3. Bereavement and Loss  |  | 7. Improve overall wellbeing |  |
| 4. Support following life/relationship changes |  | 8. Other…………………………………………………………… |  |
|  |
| Please provide any further relevant information that we may need to be aware of, including any current medication: |
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| **Consent and further information**  |
| **\***I give consent for this referral to be forwarded to the team at Essential Space Counselling Community for the nature and purpose of which has been explained above. I understand any personal information shared about me will be treated as confidential, some of this information may be collected and used in an anonymous form for statistical, data or research purposes. **\***I understand that I have (i) the right to change my mind about being referred to the service and can withdraw consent and (ii) have right of access to my information (iii) that some members of our team are Counsellors in training, however this will not affect the level of care and service I will receive.  |
| Signed: |  |