**USW Therapy**

REFERRAL FORM

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Date of Referral** |  |
| **Name** |  | **Date of Birth** |  |
| **Address** |  | **Gender** *(delete as appropriate)* | Male / FemaleOther / Prefer not to say |
| **Home Phone** |  | **Mobile Phone** |  |
| **Email** |  | **OK to leave voicemail/text?** | Yes / No |
| **Please list any safety concerns we need to be aware of regarding safe contact of the above named person:** |
|  |
| **Does the above named person prefer to receive communication in Welsh or English?** | Welsh | English |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Surgery**  |  | **Primary GP** |  |
| **Is the above named person involved with any other mental health professionals:** |
|  |
| **If so, does the above named person have a ‘Care Plan’ in place?** | Yes / No |
| **Please list any disabilities, language/communication issues or additional needs that we need to be aware of:** |
|  |

|  |
| --- |
| **For statistical purposes, please tick any which may apply to the above named person:** |
|  | Staff / Student at University of South Wales |  | Currently receiving counselling elsewhere |
|  | Black of Ethnic Minority |  | Asylum Seeker / Refugee |  | Gypsy / Traveller |

|  |  |
| --- | --- |
| **Please identify what pathway you are referring into the service via:** | Self-Referral / Statutory / 3rd Sector |
| **If Self-Referral, where did you hear about us?** |  |
| **If Statutory/3rd Sector, please complete the following details:** |
| **Referred by** |  | **Role** |  |
| **Organisation** |  | **Contact Details** |  |