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**Young Women’s Therapy Service**

**REFERRAL FORM**

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| **Referral details** | |
| **Date of Referral:** |  |
| **Referred by: Self/ other (please state)** |  |
| **Organisation:** |  |
| **Address:** |  |
| **Contact number:** |  |
| **E-mail:** |  |
| **Relationship to the client:** |  |

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| --- | --- | --- |
| **Client details** | | |
| **Name** |  | |
| **Date of birth** |  | |
| **Address:**  **Postcode:** |  | |
| **Telephone number landline:** | Is it OK to leave a message?  Yes🞎 No 🞎 | |
| **Mobile number:** | Is it OK to leave a message? Yes🞎 No 🞎  Voicemail? 🞎 Text? 🞎 | |
| **Email Address** |  | |
| **If it is difficult for a therapist to contact you by telephone would you prefer correspondence by letter?** | YES 🞏 NO 🞏  If so, and the address for correspondence is different from the one given above, please give the alternative address below: | |
| **GP Practice:** |  | |
| **GP Postcode:** |  | |
| **Please give details of any disabilities:** |  | |
| **Prescribed medications** |  |  |
| **Previous experience of counselling/therapy?** | Please provide brief details | |

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| **Next of kin/significant adult  Please only use a person who we can contact in an emergency** | |
| **Name** |  |
| **Relationship to client** |  |
| **Address** |  |
| **Contact number:** |  |

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| **Presenting issues** | |
| **Reason for referral** |  |
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| **Relevant personal and social history** |
| *Please include relevant background information this is not compulsory but very useful if it is provided. History of abuse/violence/neglect/substance use (self/others)/ physical health / Family/ relationships/*  **Please** |

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| --- |
| Signature ........................................................... Date .....................................................  Signed by (Name) ..................................................................................................................  Young Person .........................................................................................................................  Other (please state) ............................................................................................................... |

**When completed, please send this form to**

[**youngoasistherapy@oasisproject.org.uk**](mailto:youngoasistherapy@oasisproject.org.uk)

**or post to; Young Oasis Therapy, Globe House, 3 Morley Street, Brighton, BN2 9RA**

**Tel. 01273 696970 ext 0303.**