**Freshwinds – Counselling Service Referral Form**

**Please write clearly in black ink or complete by computer**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **A.** | **Referring Person (if applicable)** | | | | | |
| **Name** | |  | | | | |
| **Position** | |  | | | | |
| **Organisation** | |  | | | | |
| **Address** | | **Post Code:** | | | | |
| **Telephone No.** | |  | | | | |
| **Email** | |  | | | | |
| **B.** | **Patient’s Details** | | | | | |
| **First Name** | |  | | | | |
| **Last Name** | |  | | | | |
| **NHS No.** | |  | | | | |
| **Date of Birth** | |  | **Age** |  | | **Male ⭘ Female ⭘** |
| **Address** | | **Post Code:** | | | | |
| **Telephone No.** | |  | | | | |
| **Email** | |  | | | | |
| **Ethnicity** | | **(Optional)** | **Main Language** | | | **(Optional)** |
| **Occupation** | | **(Optional)** | **Marital Status** | | | **(Optional)** |
| **Religion** | | **(Optional)** | **Sexuality** | | | **(Optional)** |
| **C.** | **Main Carer’s Details (if applicable)** | | | | | |
| **Name** | |  | **Relationship** | |  | |
| **Telephone No.** | |  | | | | |
| **D.** | **GP Details** | | | | | |
| **Name** | |  | | | | |
| **Address** | | **Post Code:** | | | | |
| **Telephone No.** | |  | | | | |
| **Email Address** | |  | | | | |
| **Fax No.** | |  | | | | |

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| **E.** | **Disabilities Information** |
| **Please provide information of any disabilities you have** | |  |  |  | | --- | --- | --- | | Behaviour and emotional | Hearing | Manual dexterity | | Memory, concentrate or learning disability | Mobility and gross motor | No disability | | Perception of physical danger | Personal, self care and continence | Progress conditions (HIV, cancer, fits etc) | | Sight | Speech | Not stated/declined | | Other (please add to notes) |  |  | |
| **If you ticked any of the above, please expand here** |  |
| **Do you have a Long Term Physical Health Condition not listed above? If so, please note here** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **F.** | | **About your therapy** | | | | | |
| **Would you prefer a Male or Female therapist?** | | | | | **Male ⭘** | **Female ⭘** | |
| **Would you prefer AM or PM time slots (subject to availability)** | | | | | **AM ⭘** | **PM ⭘** | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Please answer both sets of questions below to help us to evaluate the best support for you** | | | | | | **Over the last 2 weeks, how often have you been bothered by the following problems?** | | | | | | **Question Set 1** | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** | | 1. **Little interest or pleasure in doing things.** |  |  |  |  | | 1. **Feeling down, depressed or hopeless.** |  |  |  |  | | 1. **Trouble falling or staying asleep, or sleeping too much.** |  |  |  |  | | 1. **Feeling tired or little energy.** |  |  |  |  | | 1. **Poor appetite or overeating.** |  |  |  |  | | 1. **Feeling bad about yourself – or that you are a failure or have let you or your family down.** |  |  |  |  | | 1. **Trouble concentrating on things, such as reading the newspaper or watching TV.** |  |  |  |  | | 1. **Moving or speaking slowly that other people could have noticed – being so fidgety or restless that you have been moving around a lot more than usual.** |  |  |  |  | | 1. **Thoughts that you would be better off dead or hurting yourself in some way.** |  |  |  |  | | **Question Set 2** | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** | | 1. **Feeling nervous, anxious or on the edge.** |  |  |  |  | | 1. **Not being able to stop or control worrying.** |  |  |  |  | | 1. **Worrying too much about different things.** |  |  |  |  | | 1. **Trouble relaxing.** |  |  |  |  | | 1. **Being so restless that it is hard to sit still.** |  |  |  |  | | 1. **Becoming easily annoyed or irritable.** |  |  |  |  | | 1. **Feeling afraid as if something awful might happen.** |  |  |  |  |   **Next steps**: if you are eligible to receive support through the project, one of our Administrators will be in touch soon to book future appointments with you.  **Please note:** it is **extremely important** that you attend all sessions booked for you. If you need to cancel your sessions we do require a 48 hour notice period in order to offer the session slot to another individual  **By signing the application form below you are confirming that all information on this form is correct. Any information which is not true may result in cancellation of your appointments and discharging from Freshwinds’ services.** | | | | | | | |
| **Signature:** | | **……………………………………………………** | | | |
| **Date** | | **……………………………………………………** | | | |
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| **Please return this form to:**  **By Post:** Freshwinds, Prospect Hall, 12 College Walk, Selly Oak, Birmingham, B29 6LE  **Fax:** 0121 415 6699  **Email**: [Sheila.Tomkins@freshwinds.org.uk](mailto:Sheila.Tomkins@freshwinds.org.uk) |