

CONFIDENTIAL – COUNSELLING REFERRAL FORM

If you are making this application on behalf of someone else please provide your contact details in this box. To make this application you will need to have the person's consent before completing. The person will need to sign the application form. If not please read below and complete the form that follows.

Name of referrer:

Contact details of referrer:

Name of person application is for:

Signature of person application is for:

Breathe provides counselling to people with mental health issues. So, you will need to complete this application form to access our services. This will give us some basic information about you and how we may be able to help.

Data Protection

To apply for counselling we ask for consent to hold and process any personal, confidential information about you which will be used, as part of the counselling process, such as your contact details, notes and assessment forms. The information held will be in digital and clerical formats; we do not pass your personal information onto anyone else without your consent in the first instance.

How we use information

- To help inform decisions that we make about your referral.
- To work effectively with other organisations who may be involved in your support.
- To ensure our services can meet your needs.
- To be able to provide you with the highest standard of counselling possible.

How information is retained and kept safe?

Information is retained in secure electronic and paper records and access is restricted to only those who need to know, removing your identifying information, adhering to strict contractual conditions and ensuring strict sharing or processing agreements are in place. It is important that

Breathe:

information is kept safe and secure, to protect your confidentiality. There are a number of ways in which your privacy is shielded by removing your identifying information, adhering to strict contractual conditions and ensuring strict sharing or processing agreements are in place.

The information shared may be used for the planning and delivery of services, additionally it may be used for statistical purposes where appropriate to do so. Information collected will be stored securely and used anonymously.

These arrangements will be in place for a period of three years after you have completed your counselling, or until you decide to withdraw consent (if you do so prior to the 3 years passing). This form will be reviewed with you when you start counselling. It will be destroyed once no longer valid i.e. when review is due or when you withdraw consent.

Please complete:

I(Print name) give consent for Breathe counselling service to hold and process any personal data which may be needed for the counselling process.

Signed:

Date:.....

Thank you

Breathe Counselling Service

PLEASE NOTE THAT WE HAVE A DUTY OF CARE TO SHARE INFORMATION ABOUT RISK WITH OTHER RELEVANT SERVICES AND YOUR GP. THIS WILL BE DISCUSSED WITH YOUR COUNSELLOR

Please provide as much information as possible so that we can allocate the most appropriate counsellor to support you. Failure to disclose relevant information may delay your referral

If we feel that the support you need cannot be undertaken at Breathe, where possible, we will provide information on alternative services that you may be able to access.

Please note that there is a charge for counselling: from £50.00 per session (initial assessment £15) for those who are waged; £5.00 per session, including initial assessment (unwaged). We may ask to see evidence of any benefits you receive.

Name	
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Breathe:

Address		
Contact Number		
Email Address		
Gender I identify my gender as	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans <input type="checkbox"/> _____ (fill in the blank)	D.O.B
Ethnicity	Ethnic Group	Religion
Next of Kin		
Next of Kin Address		
Next of Kin Number		
Name of GP		
GP's Address		
Telephone Number		
Social Worker/CPN		
Telephone Number		

Reason for Referral – The situation why you require counselling		
Aims & Objectives – What you hope to achieve		
Are you taking any prescribed medication?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Risk History and Current Risk		
Have you had any thoughts of harm to self or others? If Yes please provide more details below		
Do you have any indicators that could trigger changes to the above risks? If Yes please provide more details below		
Are you known to Social Services or NHS mental health services?		
Please provide information below regarding any services you are involved with and any issues related to these services		
Please tick if you use any of the following		
Alcohol:	Tobacco:	
Drugs:	Caffeine:	
	Other:	

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Please tick if you are affected by any of the following		
Anxiety <input type="checkbox"/>	Emotional Abuse <input type="checkbox"/>	Sexual Abuse/Assault <input type="checkbox"/>
Anger <input type="checkbox"/>	Family Difficulties <input type="checkbox"/>	Sexual Identity Issues <input type="checkbox"/>
Academic Difficulties <input type="checkbox"/>	Family Separation/Divorce <input type="checkbox"/>	Sleeping Difficulties <input type="checkbox"/>
Behaviour <input type="checkbox"/>	Financial Difficulties <input type="checkbox"/>	Stress <input type="checkbox"/>
Bereavement / loss <input type="checkbox"/>	Health (Physical) <input type="checkbox"/>	Social need (housing/finance) <input type="checkbox"/>
Bullying <input type="checkbox"/>	Physical Abuse <input type="checkbox"/>	Suicidal thoughts /behaviours <input type="checkbox"/>
Depression <input type="checkbox"/>	Relationship Difficulties <input type="checkbox"/>	Substance Abuse/Addictions <input type="checkbox"/>
Domestic Violence <input type="checkbox"/>	Self-harm <input type="checkbox"/>	Trauma <input type="checkbox"/>
Eating Issues <input type="checkbox"/>	Self-worth/Self esteem <input type="checkbox"/>	
Employment status	Employed <input type="checkbox"/>	Unemployed/Student <input type="checkbox"/>
Do you have any mobility issues? <input type="checkbox"/>		
Are you able to climb one flight of stairs? <input type="checkbox"/>		
Do you have a preference for a Male <input type="checkbox"/> or Female <input type="checkbox"/> counsellor		
No preference <input type="checkbox"/>		

Breathe:

Would you like to work with a particular counsellor at Breathe? If so, which counsellor?

Do you have a preference for Morning Afternoon Evening appointment

No preference

How did you hear about Breathe? Google Social Media Word of mouth

Counselling Directory Psychology Today Flyer

Other:

THANK YOU FOR COMPLETING THIS FORM

Please return to Breathe, 1 Pen-y-Lan Road, Roath, Cardiff, CF24 3PG

Telephone 029 2044 0191

Email: Counselling@breathe-uk.com

Please allow 3 – 5 working days for your form to be processed and booked in for an assessment