



Request for Counselling/Psychotherapy

CONFIDENTIAL

Thank you for completing this form. Answering as fully as possible will help us ensure you are seen as quickly as possible and help us to appropriately allocate the funding we receive. We will use the information you provide here to allow us to contact you in relation to our therapeutic services only. For further information about how we treat the details you provide, please read our Privacy Notice on our website or speak to a member of staff.

COMPLETE FOR ALL CLIENTS - ADULT, CHILD OR YOUNG PERSON

Name (BLOCK CAPITALS) _____

Address _____

Postcode (ESSENTIAL) _____ Telephone No _____

E-mail Address _____

Date of Birth (ESSENTIAL) _____ Age at present _____

Signed _____ Date _____

GP Name and Contact Details _____

- Have you directly or indirectly, been touched by NI conflict? YES NO
- Have you been affected by sexual, emotional, or domestic abuse/violence? YES NO
- Are you 16 or under? YES NO
(for 16 and under please also read and complete the reverse side of form)

Is your referral relating to? (PLEASE TICK AS APPROPRIATE)

- Trauma Relationships Health Issues Anxiety / Stress
- Low Mood Self Esteem Confidence Bereavement/Loss
- Other _____
- _____

PLEASE COMPLETE THIS SECTION IF THE REFERRAL IS BEING MADE BY A HEALTH / EDUCATION PROFESSIONAL, AN AGENCY, AN ORGANISATION

Referral agent's signature _____ Date _____

Name in block capitals _____

Organisation _____ Role _____

Telephone number _____

Address _____

Please return to: Clinical Co-ordinator, Aisling Centre, 37 Darling Street, Enniskillen, Co Fermanagh, BT74 7DP

FOR CHILDREN & YOUNG PEOPLE AGED 16 AND UNDER

IMPORTANT NOTES:

- Play Therapy and Counselling for children & young people is a limited service, available to:
 - those coping with bereavement or loss. **[children 5 yrs.+ and in Primary School]**
 - those experiencing trans-generational impact of the NI Troubles. **[5yrs. to 16yrs.]**
- The Aisling Centre requires permission from a parent or person with parental responsibility for children and & young people 16 and under to engage in therapy.
- It is our preference, where parental responsibility is shared, that both parties consent to, or at least know, that this request for counselling has been made on behalf of the child/young person.

PROCEDURE AFTER A REFERRAL IS RECEIVED FOR A CHILD/YOUNG PERSON

When a therapy place becomes available, a meeting will be arranged between the child / young person, the therapist and the person/s holding parental responsibility. The following will be agreed during the initial meeting:

- Confidentiality boundaries
- Participants to the counselling sessions
- Periodic reviews with the child/young person

Is your referral relating to? (please tick as appropriate)		
Bereavement <input type="checkbox"/>	Family Separation <input type="checkbox"/>	NI Conflict Related Trauma <input type="checkbox"/>
Additional information _____		
How long has the Child/Young Person been coping with this issue? _____		
Is the Child/Young Person aware that this referral has been made on their behalf? YES NO		

Parent / Person with parental responsibility (PRINT) _____	
Signature _____	Phone _____
Parent / Person with parental responsibility (PRINT) _____	
Signature _____	Phone _____
DATE: _____	

**If you have any questions about referral of children or young people,
please phone the Clinical Co-ordinator at the Aisling Centre 6632 5811**