CONFIDENTIAL

Request for Counselling/Psychotherapy

Aisling centre
Hope Healing Growth

Name (block capitals)

Address

Post code (essential) *Telephone No*

Date of birth (essential) **Age at present*

Signed *Date*

GP Name & Contact Details

** If aged 16 or under, please complete the section on the back of this form*

Main issue prompting you to seek counselling/psychotherapy

Please tick the most appropriate issue for you. It may be necessary to tick more than one box. This helps us ensure that you are allocated the most appropriate appointment within the shortest waiting time possible.

Trauma	☐	*Sexual abuse*	☐	*Physical Abuse*	☐	*Emotional Abuse*	☐
Low Mood	☐	*Relationships*	☐	*Bereavement/Loss*	☐	*Confidence*	☐
Anxiety / Stress / Panic Attacks	☐			*Troubles/Conflict*	☐	*Self Esteem*	☐

Other (please expand):

I prefer to indicate my issue when I meet in person with a therapist ☐

Is this your first request for counselling with the Aisling Centre? *Yes* ☐ *No* ☐

Please complete this section if being referred by a GP/healthcare professional/school/etc.

Referral agent's signature Date

Name in block capitals

Organisation Role

Telephone number

Address

Referral agents may attach any additional relevant information

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

Thank you for completing this form

March 2014

Please complete this section for children/young people aged 16 and under

Please note our therapy service for children/young people is limited to services for children/young people coping with bereavement/loss or experiencing the trans-generational impact of the NI Troubles

Child/Young Person's Name _____

Name of person with parental responsibility _____

Name in block capitals _____

Relationship to Child/Young Person _____

Address _____

Telephone number _____

Please give more detail on issue prompting you to seek Counselling/Psychotherapy

Bereavement ☐ *Family Separation* ☐ *Illness* ☐ *Conflict Related Trauma* ☐

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 ☐

Parental Consent

It is necessary to gain permission from a parent/person with parental responsibility for counselling to take place with a child/young person aged 16 and under. The person named in the box above must therefore hold parental responsibility. 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 are agreed at the initial meeting:-

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

Signed: _____ *Date:* _____

Signed: _____ *Date:* _____

(Adult/s with parental responsibility for above named child/young person)