For internal use only:

Ref No: _____ **Contract:** _____

Ack: Client □ Referrer □ No □

Aisling centre
Hope Healing Growth

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.

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** □

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

Trauma	□	Relationships	□	Health Issues	□	Anxiety / Stress	□
Low Mood	□	Self Esteem	□	Confidence	□	Bereavement/Loss	□

Other _____

_____

ARE YOU AVAILABLE FOR AN APPOINTMENT AT SHORT NOTICE □

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 Lead, Aisling Centre, 37 Darling Street, Enniskillen, Co Fermanagh, BT74 7DP