**The AOC Therapy Group Referral Form**

To Complete this referral form you MUST be 18+ years old.

Are you aware this referral form is for group session therapy? Yes No

Are you filling out this referral form on behalf of someone? Yes No

If yes, do you have permission to fill out this form? Yes No

If yes, does the person know they are being referred? Yes No

**If you are filling out this referral form on behalf of someone, please provide your details in section C on page 5 .**

**Please list below the details of the person wishing to receive group therapy/counselling and please complete the appropriate sections.**

|  |  |  |
| --- | --- | --- |
| **Section A:**  **Full Name:** | | |
| **Male Female** | **Date of Birth:** | **Age:** |
| **Address & Poscode:** | | |

**Contact Numbers: (Home) Mobile:**

**Preferred method of contact: Phone  Email  Post **

**Email Address:**

**Please note all group therapy sessions will take place either at The AOC building or at a venue determined by the therapist or counsellor.**

**Section B:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Ethnicity:** | **African** | **Asian** | **Bangladeshi** | **White/Black Caribbean** |
| **White** | **Pakistani** | **Caribbean** | **Any other Asian** | **White/Asian** |
| **Irish** | **Jewish** | **Gypsy/Roma** | **Any Other Mixed** | **White/Black African** |
| **British** | **Chinese** | **Indian** | **Any Other Black** | **Other Ethnicity** |
| **Main Language Spoken by client:** | | | | |

**GP Name / Address & Contact Number:**

|  |
| --- |
| **Do you receive psychiatric support? Yes  No**  **If Yes please give details:** |

**Do you have any disabilities? Yes  No **

**If Yes, details:**

**Do you have any medical conditions? Yes  No **

**If Yes, details:**

**Are you currently on any medication? Yes  No **

**If Yes, details:**

**Are you involved with Social Care and Health? Yes  No **

**If Yes, details:**

**Are there or has there been any identified child protection issues related to you or your family? Yes  No **

**If Yes, details?**

**Is the child on a Child Protection Plan? Yes  No **

**Has the case been referred to the police? Yes  No **

**Is the case open or closed after Court Case / Police Investigation:**

**Open  Closed **

|  |
| --- |
| **Are you awaiting any court hearings, in prison, awaiting sentencing, on probation, or have any criminal convictions, please give brief details:** |

**In the next box please provide details of why you wish to join a therapy group. Please record briefly past issues and problems as well as difficulties currently present.**

**Please tick the following boxes which apply to the client’s referral**

**Abuse  \*Physical, emotional, psychological, sexual, neglect**

**Self-Harm  Attempted Suicide **

**Affected by Domestic Abuse  \*Direct / Indirect**

**Separation Issues **

**Signed by Client wishing to join Therapy Group:**

**Date:**

**Section C:**

**Referrer Details:**

*Relationship / Role to client: (eg: mother, son, doctor, nurse, teacher) if completing this for yourself just put N/A.*

*Referrer’s Full Name:*

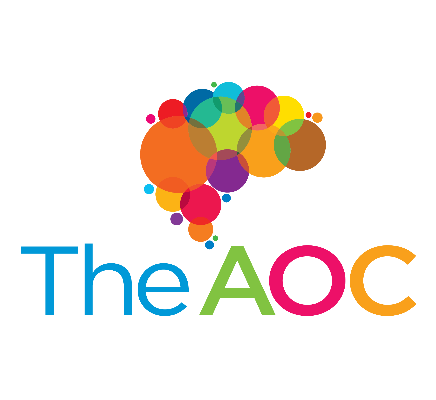
*Agency / Organisation Address: (If completed by someone else on your behalf who is not a family member)*

*Phone Number: Mobile Number:*

*Email Address:*

*Date Referral Completed:*

*Referrers Signature:*



**Return Forms to: The Arts of Change,  
 27 Holloway Chambers,  
 Priory Street, Dudley,  
 West Midlands,  
 DY1 1HA. 01384 211 168.**

**Email: - support@theaoc.org.uk**