



The AoC Individual Therapy Referral Form

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

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

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

If yes, does the clients 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 D on page 6.

Please list below the details of the person being referred to receive therapy/counselling and please complete the appropriate section.

Section A. Individual:		
Full Name:		
<input type="checkbox"/> Male	Female <input type="checkbox"/>	Date of Birth:
<input type="checkbox"/> Adult	Child <input type="checkbox"/>	Age:
		School: (if appropriate)
Full Address:		
Contact Number (Home):		Mobile:
Preferred method of contact: Phone <input type="checkbox"/> Email <input type="checkbox"/> Post <input type="checkbox"/>		
Email Address:		

Appointment Availability (please state preferred days & times):



Preferred location/venue for appointments:

The AOC Local School/Community Centre Other

If Other, please specify:

Please note if you prefer to receive counselling/therapy support and you would like sessions to take place away from our offices you are responsible for booking the required venue. This is also subject to availability as not all our therapeutic clinicians lone work.

Section C:

Ethnicity:	<input type="checkbox"/> African	<input type="checkbox"/> Asian	<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> White/Black Caribbean
<input type="checkbox"/> White	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Caribbean	<input type="checkbox"/> Any other Asian	<input type="checkbox"/> White/Asian
<input type="checkbox"/> Irish	<input type="checkbox"/> Jewish	<input type="checkbox"/> Gypsy/Roman	<input type="checkbox"/> Any Other Mixed	<input type="checkbox"/> White/Black African
<input type="checkbox"/> British	<input type="checkbox"/> Chinese	<input type="checkbox"/> Indian	<input type="checkbox"/> Any Other Black	<input type="checkbox"/> Other Ethnicity

Main Language Spoken by client:

GP Name / Address:

If you have children do any of them currently supported by CAHMS:

Yes No

If Yes, details:



Do you (the client) have any disabilities? Yes No

If Yes, please give details:

Do you (the client) have any medical conditions? Yes No

If Yes, please give details:

Are you (the client) currently on any medication? Yes No

If Yes, details:

Are Social Care and Health involved with you (the client)? Yes No

If Yes, details:

Are there or has there been any identified child protection issues related to you (the client)? Yes No

If Yes, details?

Has the case been referred to the police? Yes No

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

Open Closed



In the next box please provide details of why you are requesting individual therapy/counselling. Please record past issues and problems as well as difficulties currently present.

Are you (the client) awaiting any court hearings, in prison, awaiting sentencing, on probation, or have any criminal convictions, please give brief details:



Please tick the following boxes which apply to the client's referral

Abuse <input type="checkbox"/> *Physical, emotional, psychological, sexual, neglect
Self-Harm <input type="checkbox"/> Attempted Suicide <input type="checkbox"/>
Affected by Domestic Abuse <input type="checkbox"/> *Direct / Indirect
Separation Issues <input type="checkbox"/>
Signed by:
Date:

By signing the referral form you agree to share your information with The AoC and The AoC Trust. Your data will be shared amongst relevant AoC staff including management, administration, and your allocated therapeutic clinician. Your data will not be shared with any third parties outside of The AoC unless there is a relevant safeguarding concern. Data will be shared on a need-to-know basis only. If you have any concerns regarding this, please do not hesitate to contact us. You can also request a copy of our data protection policy to see how your data is managed and kept safe.



Section D:

Referrer Details:

<i>Referrer's Full Name:</i>	
<i>Relationship / Role to client: (eg: mother, son, doctor, teacher)</i>	
<i>Agency / Organisation Address:</i>	
<i>Phone Number:</i>	<i>Mobile Number:</i>
<i>Email Address:</i>	
<i>Date Referral Completed:</i>	
<i>Referrer's Signature:</i>	



Return Forms to: The Arts of Change / The AoC
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