**Referral form**

Thank you for contacting Terapia. Please take a few minutes to fill in our referral form so that we can help you to access the best support.

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| **Date referral sent:** |  |
| **Name of client being referred:** |  |
| **D.O.B of client being referred:** |  |
| **Gender of client being referred:** |  |
| **Name of referrer (if different from client):** |  |
| **Relationship of referrer to client (if client is a child):** |  |
| **Address of client:**  **Address of referrer (if on  behalf of child but living apart):** |  |
| **Email address of client (or parent/carer guardian for child):** |  |
| **People living in the client’s household:** |  |
| **Phone number of client (if adult):** |  |
| **Phone number of parent/carer/ guardian (if client is a child):** |  |
| **Emergency contact details for the client:** |  |
| **Ethnicity of client:**  (Optional) |  |
| **Religion of client:**  (Optional) |  |
| **Sexual orientation of client:**  (Optional) |  |
| **Current nursery, school, college name and address of client:** |  |
| **Occupation of client (if adult):** |  |
| **Occupation of parent/carers/guardian (where client is a child):** |  |
| **GP name and address of the client:** |  |
| **Any significant medical condition/medication:** |  |
| **Current or historic CAMHS intervention:** | Current  Historic None  |
| **Current or historic social work intervention:** | Current  Historic None  |
| **Please tick the presenting concerns the client is looking to address in therapy** (tick as many as feel relevant): | Depression   Anxiety related issues   Anger/aggression   Bereavement   Eating disorder   Mental health diagnosis   Suicidal ideation   Self-harm   Suicide attempt/s   Traumatic incident   Domestic abuse   Substance misuse   Addictions   Risk-taking behaviour   Asperger’s/Autism/ADHD   Learning difficulties   Physical disability   Gender/sexual identity   Traumatic/abusive family history   Relationship difficulties/separation   Adoption   Termination of pregnancy   Conception difficulties   Chronic pain/health issues   Parenting work   Difficulties at school/college   Bullying   General exploration of internal world   Forensic history   Other   |
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Once completed, please email this form to [referrals@terapia.co.uk](mailto:referrals@terapia.co.uk) and we will be in touch to arrange an initial phone call to discuss our service and how we can help. Please note all face to face sessions take place atThe Bothy, 17A East End Road, London, N3 3QE. If you have any queries, please contact 020 8201 6101.