**The Trauma Healing Collective CIC**

**Client Referral Form**

Please **RENAME** in your **name** or **initials** and send to: amatullah.salmon@traumahealingcollective.co.uk

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| **Section 1: Personal Details** | |
| **Full Name:** | **Date of Birth:** |
| **Address Including FULL postcode:** | |
| **Ethnicity:** | **Religion:** |
| **Phone Number:** |  |
| **Email:** | |
| **Preferred Contact Method:** | ☐ Phone ☐ Email ☐ Text ☐ Other: |
| **Emergency Contact Name:** |  |
| **Emergency Contact Phone Number:** |  |
| **Relationship to Emergency Contact:** |  |
| **Professional Referral:** ☐ **Self Referral:** ☐ | |
| **If professional referral please add details here:** | |

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| **Section 2: Presenting Issues** |
| **(Please check or bold all that apply)** ☐ Domestic Violence (DV) ☐ Sexual Abuse ☐ Mental Health Concerns ☐ Trauma/PTSD ☐ Anxiety/Depression ☐ Suicidal Thoughts/Self-Harm ☐ Substance Use  ☐ FGM ☐ Other (Please specify): |

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| **Section 3: Significant Incidents** |
| (Please provide details of any significant incidents, including dates if possible) |

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| **Section 4: Medical & Mental Health Information** |
| **Current Medications:** |
| **Prescribing Doctor:** |
| **Mental Health Diagnosis (if applicable):** |
| **Physical Health Conditions:** |
| **Allergies:** |

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| **Section 5: Previous & Current Therapeutic Support** |
| **Have you received therapy/counselling before?** ☐ Yes ☐ No |
| **If yes, please provide details:**  **Type of Therapy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Name of Therapist/Organisation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Duration & Frequency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Was it helpful?** ☐ Yes ☐ No ☐ Unsure |

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| **Section 6: Involvement with Statutory & Voluntary Agencies** |
| **Are you currently working with any agencies?** ☐ Yes ☐ No |
| **If yes, please list below:** |
| **Agency Name:** |
| **Contact Details:** |
| **Support Provided:** |

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| **Section 7: Additional Information** |
| (Please provide any other relevant information or concerns) |

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| **Section 8: Consent & Confidentiality** |
| **Do you consent to sharing this information with relevant agencies to support your needs?**  ☐ Yes ☐ No |
| **Do you require any special accommodations (e.g., interpreter, disability access)?** ☐ Yes ☐ No  If yes, please specify language: |
| **Signature of Person Completing Form: Date:** |