

**House of Healing CBT Referral Form**

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| **Name** |  | | | | | |
| **Address** |  | | | | | |
| **Post code** | |  | | | |
| **Date of birth**  **dd/mm/yyyy** |  | | | **Gender** | |  |
| **Contact number**  **Including country/area code where applicable** |  | | | | | |
| **Email** |  | | | | | |
| **GP details** |  | | | | | |
| **Post code** | |  | | | |
| **Phone number** | |  | | | |
| **Guardian details – if under 18 years old** |  | | | | | |
| **Post code** | |  | | | |
| **Relationship** | |  | | | |
| **Phone number / email** | |  | | | |
| **Reason for referral – why have you sought support now? What do you hope therapy can help you with?** |  | | | | | |
| **Previous mental health history or treatment** |  | | | | | |
| **Do you experience suicidal thoughts, self-harm or any other mental health risk?** | | |  | | |
| **Method of therapy sought** | **Video therapy** | **Telephone therapy** | | | **Live Type therapy** | |
| **Availability for sessions** Please indicate days you are available |  | | | | | |
| **AM / PM / Evening** | | | | | |
| **How did you hear about House of Healing CBT?** |  | | | | | |
| **Please note: this information and any information from sessions is not shared with your GP, however in the event of risk to your life i.e. suicide, confidentiality will be breached in your best interests by sharing Information with your GP or emergency services.** | | | | | | |
| **Please now save the form and return it via email to houseofhealingcbt@outlook.com**  **I will endeavour to respond to your referral within 48 hours.** | | | | | | |