REF NUMBER: _____

DATE OF REFERRAL: _____

Midlothian Sure Start

Therapy Services
REFERRAL FORM

Do you attend a centre or service already? *(Please tick)*		** Which aspect of the Therapy Service is of interest to you? *(Please tick)*	
Stepping Forward		Individual Counselling	
Bright Start		Therapeutic Group Work – Art Therapy & Relaxation	
Hand in Hand		– Antenatal / Postnatal Therapy	
Family Reachout			
Positive Steps		** Only **ONE** aspect of the service can be attended at any given time.	
Small Steps		*Please add any comments below*	
Dad's Co-ordinator			
Grandparents Co-ordinator			
Empowering Families Project			

About You			**Referrer**		
Please complete			Please complete		
Self Referral	YES	NO	Referral/Supporter Agent	YES	NO
Client Name/s			Name/s		
Address			Organisation Address		
Post Code			Post Code		
Can we use this address to send therapy service information ?	YES	NO	Telephone		
Telephone			Email Address		
Date Of Birth			Child/Children's Names & Dates Of Birth **		
Ethnicity			Child 1 Name		Child 1 DOB
Email Address			Child 2 Name		Child 2 DOB
Please add any comments below			Child 3 Name		Child 3 DOB
			Child 4 Name		Child 4 DOB
			Child 5 Name		Child 5 DOB
			** *If more space is required, please continue on a separate sheet*		

IMPORTANT		
We need to know if it is –	*Please circle*	
O.K. to phone	YES	NO
O.K. to leave a message on your Answer Phone	YES	NO
O.K. to write to you	YES	NO
O.K. to email you	YES	NO

Reason For Referral? *(Please tick any of the following)*	
Anxiety	
Stress	
Postnatal Depression	
Grief / Loss	
Trauma / Abuse	
Relationship difficulties within family (NB. Couple Counselling Lothian offers specific Couples Services)	
Other (Please state below)	

How did you hear of Midlothian Sure Start's Counselling Service? *(Please tick any of the following)*	
Leaflets	
GP / Health Visitor	
Friends	
Other (Please state below)	

What Support do you feel you need at this time? *(Please state below)*	**What services/other agencies do you/your client(s) use at this time?** *(Please state below)*

Availability for appointment - preferred days and times *(please circle)*		
DAYS: Mon Tue Wed Thu Fri	**TIME: Morning**	**Afternoon**
Any mobility or access problem ?	YES	NO
Do you require childcare ?	YES	NO
Is the person aware of this referral ?	YES	NO
Do they agree to this referral being made ?	YES	NO

Consent is required from the individual for this information to be forwarded to Midlothian Sure Start and further enquiries made. **It is preferable to have a signature but, referral can proceed if the client is not present to sign.**

Please complete all details below	
Client Signature:	Date:
Print Name:	
Title:	
Referrer's Signature	Date:
Print Name:	
Contact Tel No:	

Please return this completed form to: Anna Gibbons
Clinical Lead
Therapy Services
Midlothian Sure Start
14-15 Bogwood Court
Mayfield
EH22 5DG