**Adult Counselling Self-Referral Form**

**Please use this form to self-refer to our face-to-face or online counselling services for adults.**

**Please complete all the information requested and return to:**

**counselling@bucksmind.org.uk**

**If you would prefer to post your referral, please send it to:**

**Buckinghamshire Mind, 260 Desborough Road, High Wycombe, Bucks, HP 11 2QR**

|  |  |
| --- | --- |
| **Title** |  |
| **Full name (required)** |  |
| **Email address (required)** |  |
| **Date of birth****(required)** |  |
| **Address (required)** |  |
| **Postcode (required)** |  |

|  |  |
| --- | --- |
| **What counselling service would you like to access?** | **Face to face** [ ] **Online** [ ] **Not sure** [ ]  |

**Is it ok to say Buckinghamshire Mind if we call or leave a message?**

**Delete YES/NO as appropriate**

|  |  |  |
| --- | --- | --- |
| **Home** |  | **YES/NO** |
| **Work** |  | **YES/NO** |
| **Mobile** |  | **YES/NO** |
| **E-Mail** |  | **YES/NO** |

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**What is your preferred time for an appointment? Please tick below:**

[ ]  Mon – Fri (9am to 12noon) [ ]  Mon - Fri (12noon to 5pm)

Please note that we can’t guarantee appointments at your preferred time, but we will try our best to accommodate your preference.

**Presenting Issues: tick those that are applicable**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Anxiety |  | Anger |  | Alcohol |  |
| Bereavement |  | Depression |  | Drugs |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Domestic Violence |  | Eating disorder |  | Lack of confidence |  |
| Low self-esteem |  | OCD |  | Personality Disorder |  |
| PTSD |  | Relationships |  | Self-harm |  |
| Sexual abuse |  | Sexuality |  | Schizophrenia |  |
| Stress |  | Work |  | Covid-19 |  |

**What are the three main reasons for your referral? (Required)**

|  |  |
| --- | --- |
| **1.** |  |
| **2.** |  |
| **3.** |  |

**In the last 5 years have you received support from any other psychological service such as Complex Needs, AMHS, Crisis Support/Specialist support? (required)**

***Please tick***

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**If Yes, please provide details:**

|  |
| --- |
|  |

**How did you hear about our service, please tick.**

**(required)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| GP |  | Friend/relative |  | Healthy Minds |  |
| Search Engine |  | NHS Mental Health Service |  | Other |  |

**Consent**

When I submit this form, I give my consent for Buckinghamshire Mind to store and process my personal data in order to respond to my request.

Signed Dated: