**Adult Counselling Self-Referral Form**

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

**Please send it to:**

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

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| --- | --- |
| **First name (required)** |  |
| **Surname (required)** |  |
| **Preferred name** |  |
| **Date of birth**  **(required)** |  |
| **Preferred pronouns** |  |
| **Accessibility requirements** |  |
| **Address (required)** |  |
| **Postcode (required)** |  |
| **Telephone (required\_** |  |
| **Email** |  |
| **Preferred contact method** | **Mail / email / telephone / text / other** |
| **Other contact information, such as for your support / social worker. Also let us know if we should not leave a voicemail on your mobile number.** | |
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**Consent**

**Privacy statement:**

We need to keep some information about you to give you the right support at Bucks Mind.

When you start a service we need to know things like your name, date of birth, address and phone number so we can get to know you, work with you in the best way and contact you if necessary. We also collect information about your ethnicity, religion and gender which we use to check we are reaching all groups of people in the community.

For some services, we collect other information like your GP or mental health worker and your current health and wellbeing. This is important so we understand how you are, how we can best support you, and who to contact if we are worried about you. For services where we complete a support plan with you, we may ask you what you like doing and what your goals are so we can help you achieve them. Some people’s stories and photos make lovely case studies and we may ask your permission to share these to show how our services can help people.

We are a confidential service and want you to feel safe and respected. We will always ask you before we share information about you and we will tell you what we are doing and why. Information about you is private which is why we check with you first. If you were to become very unwell or were unable to make your own decisions (we call that lacking capacity) then we may share information if we felt you or someone else may be in danger. This may be with a GP, family member or someone else who supports you to make sure you are safe.

We only keep information if we really need it, we usually keep it for 6 years once you have finished with the service and we look after that information carefully.

If you would like to read our full Privacy policy, please visit our website: [Privacy Statement (UK) - Bucks Mind](https://www.bucksmind.org.uk/privacy-statement-uk/?cmplz_region_redirect=true&cmplz-region=uk)

**Do you give consent to collect, process and store your information?**

Yes/no

**Do you give consent to share data with third parties**

Yes/no

**Do you give consent to receive newsletters/occasional emails from Bucks Mind**

Yes/no

**Who is making this referral?**

Myself

Parent/guardian/relative

GP/other health professional

Other

**How did you hear about this service?**

GP

Social care

Community mental health team

Family / friend

Talking therapies

Search engine

Social media

Promotional event (please specify which)

Other (please specify)

|  |  |
| --- | --- |
| **Where would you like to access counselling?** | **Face to face High Wycombe**  **Face to face Aylesbury**  **Face to face Chesham**  **Online**  **Telephone** |

**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.

**What would you like support with? tick those that are applicable**

|  |  |  |  |
| --- | --- | --- | --- |
| Alcohol misuse |  | OCG |  |
| Anger |  | PTSD |  |
| Anxiety |  | Personality disorder |  |
| Bereavement |  | Relationships |  |
| Covid-10 |  | Schizophrenia |  |
| Depression |  | Self-harm |  |
| Domestic Violence |  | Sexual abuse |  |
| Drug misuse |  | Sexuality |  |
| Eating disorder |  | Stress |  |
| Lack of confidence |  | Work |  |
| Low self-esteem |  | Other |  |
| Neurodiversity |  |  |  |

**In your own words, tell us briefly the main reason(s) why you are referring for counselling.**

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**If you have received support from any other psychological service in the last 5 years, please provide details including who this was with**

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|  |

Signed Dated: