

NAOS SELF - REFERRAL FORM Please complete all sections and return to info@naos.org.uk

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| Name Contact Phone Number: |  |
| Client’s addressPostcode |  |
| Date of Initial Enquiry |  |
| How do you self-identify in terms of gender |  |
| How do you self-identify in terms of ethnicity  |  |
| Date of Birth  |  |
| How will you fund your therapy?  |  |
| Why would you like therapy now and what are you hoping to achieve by attending?What would be your preferred way of working – e.g. talk therapy, art therapy, drama therapy, dance therapy music therapy, counselling psychotherapy?Do you have any preference as to the gender / age of your therapist? |  |
| U18sHas parental / carer consent been obtained if required?Please confirm details  |  |
| If Social Services are working with you have they agreed to therapy?Please confirm the name and contact details for your Social worker  |  |

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| Primary carer’s name & phone number IF UNDER 19 |  |
| Other Carer(s)  |  |
| EMERGENCY CONTACT NUMBERWho should we contact in the first instance |  |

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| --- | --- |
| G.P. name & contact details |  |
| Medication  |  |
| Any Medical Conditions that it would be useful for us to be aware of |  |
| Can you update us about any Drug and /or Alcohol use that may have impacted on your life?Past & Present |  |

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| Are you involved with a Psychiatrist/Psychologist/Counsellor?If yes, please give details. |  |
| Have you had previous experiences with Therapy?If yes, please give details. |  |

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| Reason for referral  |
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| Involvement with any statutory and or voluntary agencies – please include length of involvement and frequencyInclude contact details where known  |
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**For use by Allocation Team:**

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| Date referral discussed by the team | Name of Therapist allocated to: | Any comments: |
| Date of Initial meeting with Young Person |  |  |
| Commencement of Counselling/Therapy / Group workDate: |  |  |
| End date: |  |  |