The Aware Counselling Service

Referral Form

REFERRER DETAILS:

Category of referrer:

☐ Local NGO
☐ Primary Care provider
☐ Community Mental Health Team
☐ Liaison Psychiatry
☐ Other: _____

Referred by (please print in block capitals): _____

Email: _____

Contact number: _____

Signed: _____ **Date:** _____

CLIENT/CUSTOMER DETAILS

Name (please print in block capitals): _____

DOB: _____

Email address: _____

Contact number: _____

Geographical location: _____

Gender:

☐ Male

☐ Female

☐ Non-binary

☐ Prefers not to say

Can your client speak English?

☐Yes

☐No

Is your client currently accessing counselling elsewhere?

☐Yes

☐No

GP DETAILS:

Name: _____

Address: _____

EMERGENCY CONTACT DETAILS:

Name: _____

Contact number: _____

Has your client given permission to contact Emergency Contact if deemed necessary?

☐Yes

☐ No

REASON FOR INTRODUCTION:

NEXT STEPS:

Please email this referral form to counselling@aware.ie. Within 48hrs, a member of The Aware Counselling service will be in touch with your client/customer directly via the details provided to gather further details and begin the self-referral process.