Teach Oscail Counselling and Therapy Centre

Name (block capitals):	
Address:	
Telephone :	*Email:*
Date of birth (essential):	*Age:*
Signature of Client:	*Date:*
GP Name & Contact details:	
If aged under 18 please complete the section on the back of this form	

Main issue prompting the referral for psychotherapy/Counselling

Anxiety/stress/panic attacks □ Confidence/self-esteem □ Trauma □

Sexual Abuse □ Physical Abuse □ Emotional Abuse □ Suicidal thoughts □

Bereavement/Loss □ Relationship issues □ Addiction □ Low mood □

Other □

PLEASE EXPAND

_____

_____

_____

I prefer to discuss my issue when I meet in person with a therapist □

Teach Oscail Counselling and Therapy Centre

Please complete this section if be referred by your GP/ Healthcare Professional/School etc:	
Referral agents Signature:	*Date:*
Name in Block capitals:	
Organisation:	*Role:*
Telephone No:	
Referral agents may attach any additional relevant information	

Is this your first request for counselling from Teach Oscail Family Resource Centre

Yes □ *No* □