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| Office use only | CLOG: |

**Counselling Referral Form**

Thank you for your interest in Richmond AID’s Counselling Service.

*We need your consent to record some of your information and to contact you for* *communications relevant to the Counselling Service*. By completing this form, you agree that any personal information you share with Richmond AID will be kept secure on our databases and used in line with the General Data Protection Regulation 2018 (GDPR). 

* Please note we are a self-referral service.
* Completion of this form, or completion of an assessment, does not guarantee access to Richmond AID’s Counselling Service.
* We may discover there are other services that would better suit you, in which case we will try and support your access to these.

**Please complete below, to confirm your agreement to the terms above:**

I understand the terms of this referral and consent to my details being used and stored, as described above:

Yes ❑ No ❑ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_ **or** Verbal Consent given❑

*You can contact us to change or update your details, or ask us to delete your details from our records, just email* [*counselling@richmondaid.org.uk.*](mailto:counselling@richmondaid.org.uk.)

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| **Please complete all sections of this form so we can ensure we offer you the best service possible**.  Please email your completed form to: [counselling@richmondaid.org.uk](mailto:counselling@richmondaid.org.uk) to join our waiting list and wait to be contacted about an assessment. | | | | | | | |
| **.** Name:  **.** Preferred name: | | | | | DOB: | | |
| Contact address: | | | **.** Telephone no:  **.** Is it okay to leave a voicemail? **Y/N** | | | | |
| Email address: | | | | | | | |
| Main disability: | | | | Any access needs: | | | |
| Any medical diagnoses: | | | | Any preference for therapist gender: | | | |
| **.** Gender Identity:  **.** Is this the same as assigned at birth? **Y/N** | | Ethnicity: | | | | Sexual Orientation: | |
| Religion: | | | |
| **GP / Emergency contact details:**   * GP name: * Phone number: * Address: * Is your GP aware of contact with Richmond AID? **Y/N** * Do we have permission to contact your GP? **Y/N**   **Emergency contact:**   * Name: * Phone number: | | | | |  | | --- | | **How did you find out about us?**   * GP ❑ * Richmond Wellbeing Service ❑ * Friend / Relative ❑ * Other: | | | | |
| Reasons for seeking counselling: | | | | | | | |
| **Fees Explained:**   * All clients pay the same assessment fee (£35) * Sessions are weekly and fees are set dependent on your income. * We require evidence of income for access to our low-cost session sessions (bank statement/payslip/benefits statement).   **Please tick below to indicate which session rate fits you best:**  **Assessment Fee £35 – payable by all applicants**   * **Standard Rate sessions, up to 1yr: £40** ❑ * **Limited low-cost, up to 20 sessions (Richmond borough residents):** * Income less than £20,000 (based on single person household): **£20** ❑ * Receiving means tested government benefits: **£15** ❑ | | | | | | | |
| **Our service currently operates within the hours below.**  Please indicate to let us know the times that would best suit you | | | | | | | |
| **Wednesdays**:  1pm - 5pm |  | | | **Wednesdays:** 5pm- 8pm | | |  |
| **Thursdays:**  2pm- 5pm |  | | | **Fridays:**  10am-1pm | | |  |

Thank you for completing the referral form.

Please email your completed form to: [counselling@richmondaid.org.uk](mailto:counselling@richmondaid.org.uk)

*We aim to respond to completed forms within 10 working days.*