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 **MACP Referral Form**

**Please complete the boxes in white only. Grey boxes are for MACP office use only. Clients MUST COMPLETE THIS FORM IN FULL, so we can allocate you to the most appropriate counsellor.**

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| **Counsellor Allocation/Ref No: *(Office Use Only)*** |  |
| **Information captured by: (MACP Representative)** |  | **Date** |  |
| **Referrer/Client/Organisation** |  | **Tel No** |  |
| **Organisation & email:** |  |
|  **Client Details Only** |
| **Name/Age/Date of Birth** |  |  |  |
| **Address & postcode** |  | **Postcode**  |  |
| **Email /Mobile/Landline** |  |  |  |
| **Client Presenting Issue/****What would you like to talk about in counselling?** |  |
| **Next of Kin** |  | **Next of Kin Tel No** |  |
| **Are there any risk factors MACP should be made aware of e.g., Please insert a number from 0-10?****0 being no risk, 10 being risk imminent** | **Suicidal Tendencies** | **Self-Harm** | **Harm to others** |
|  |  |  |
| **Availability for Appointments. Please tick all that apply** | **Mornings** **9am-1pm** | **Afternoon** **1pm-5pm** | **Evening** **5pm – 9pm** | **Weekends****9am – 9pm Sat/Sun** |
|  |  |  |  |
| **Dou have a religion? If so, can we ask what your religion is?** |   | **Are you married, single living with partner or parents etc?** |  |
| **Do you have children? If so, what are your childrens first names only, and ages?** |  | **What is your occupation?** |  |
| **Are you on any medications? If so, names and dosage.**  |  |
| **Doctors Name, Address & contact details** |  |
| **Any Other Information** |  |