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| **SECTION 1****To be completed by the referral organization. (For example: a keyworker or social worker)** |  |
| **REFERRER’S DETAILS:****Name:****Position:****Relation to Client:** **Organization Name:****Organization Address:****Organization Website:****Contact Number:****How did you hear about our organization?****Have you booked an Advice Call with us?** |  |
| **SECTION 2****To be completed collaboratively with the client.** |  |
| **Client Name:** | **Date of Birth:** |
| **Preferred Pronouns:** |  |
| **Phone:****Email:**  |  |
| **Occupation:**  |  |
| **Children? (Yes/ No and ages of children):**  | **Age/s:**  |
| **Do the children live with the client?** |  |
| **Agencies involved currently and past (including any relevant agencies involved with their children):**  |  |
| **Previous therapeutic interventions the client has had:** |
| **What is important for your client, in the ‘right’ therapist?** |
| **Presenting issues/reasons for seeking therapy:** |
| **Accessibility needs or Communication Differences?** |
| **Anything else your client would like therapist to know?** (For example, sexuality, religious beliefs, gender, hidden disabilities or any other information the client feels is relevant).  |
| **SECTION 3****To be completed collaboratively with the client.** |
| **How will therapy be funded? Please tick:****Self-funded (by the client)** [ ] **By your organization** [ ] **Through an external organization** [ ] **If you have ticked ‘by your organization, please complete SECTION 3A****If you have ticked Self-funded, please fill out SECTION 3B.****If you have ticked external organization, please provide a named contact below:** |
| **SECTION 3A****If your organization will be funding therapy:** |
| **What course of therapy does the organization plan to fund? (Please indicate):**1. **Short-term: weekly therapy for 3-6 months**
2. **Long-term: weekly therapy for 6 months to 1 year**
3. **Open-ended therapy: weekly therapy with a review every 12 sessions**
4. **Other (please describe):**
5. **I am not sure. (We can discuss with you in your advice call).**
 |
| **SECTION 3B** |
| Self-funded clients may be eligible for our subsidised therapy service. This is offered to self-funding clients who could not otherwise afford therapy. For example, if you are currently:* Unemployed or under-employed
* A fulltime student
* A fulltime carer

Please note, there is currently a 3 month waiting list for our subsidised therapy service. **Please describe how your client is eligible for subsidised therapy:****Please indicate what fee you could comfortably afford\*:**\*Please note: he minimum contribution a client can make is £20 per session. |
| **If offered therapy with us, would your client prefer to pay their fees on a weekly (pay as you go) or monthly basis?** |
| \*We use a secure online diary management system to store all client details. This system is called Kiku. It allows clients to pay easily for therapy sessions, by credit or debit card.**Does your client consent to their details being stored on this secure database?****Is your client happy to pay for any future sessions by card, using this database?** |
| **Referrer:** Please sign here to confirm that you have gained explicit consent from your client to share these details with us:**Client Signature:**  |

**Date:**

**Please return this form via a secure email transcription service (such as Egress) to:**

**FAO: Kyra Hall-Gelly MBACP or Jan Hall HCPC MBACP**

**Email:** **jan@neurotribe.uk** **or** **info@neurotribe.uk**