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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**](mailto:jan@neurotribe.uk) **or** [**info@neurotribe.uk**](mailto:info@neurotribe.uk)