**This is not a crisis counselling service. If you need immediate or urgent support you can contact your GP, attend your local A&E or call the following helplines which are open 24 hours a day, 7 days a week, 365 days a year. The Samaritans is a UK wide helpline for anybody struggling with their mental health. You can call them on 116123. If you prefer to communicate via message, you can text SHOUT on 85258. You can also contact Lifeline Freephone number on 0808 808 8000**

**Please note that our counselling service is delivered via telephone or virtually (Skype, Zoom,…). Referrals should be currently made on this basis.**

|  |  |
| --- | --- |
| **Name:**  **Male/Female/Other**  **DOB:**  **Address:**  **Telephone:**  **Email:** | **Referrer Name** (if not self-referral):  **Relationship/Role:**  **Address:**  **Telephone:**  **Email:** |
| **GP Details**  **Name:**  **Address:**  **Telephone:**  **Email:** | **Next of Kin/Emergency Contact Details**  **Name:**  **Address:**  **Telephone:**  **Email:** |
| **Date of referral:** | |

|  |  |
| --- | --- |
| **History of Brain Injury (if applicable)**  **Date occurred, diagnosis, cause of injury etc.** | |
| **Has the person received counselling previously?**  **If yes, when and where?** | |
| **Known Risk Factors (e.g. risk of suicide, self-harm, self-neglect, risk to others - please indicate if these are current or previous and give dates)** | |
| **If the person is receiving support from other professionals, or on a "waiting list" for services, please give brief information** | |
| **Past Medical History** | **Current Medication** |
| **Epilepsy Yes/No** | **Seizures Yes/No** If yes, please give details of type & frequency |
| **Please state briefly the reason for referral. (NB: Any information given may be shared with the person but is otherwise confidential)** | |
| **Social** (Family situation, living arrangements – supported, lives alone etc.) | |

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| **Has the referral been discussed with the client and are they in agreement? Yes/No**  **Do we have their permission to contact them directly? Yes/No**  **Do we have consent to share information with other services (i.e. provide and receive information on their behalf)? Yes/No** |

*Please attach any further information or clinical reports that you feel may be relevant.*

**Completed forms should be returned to:**

**Email: referrals@braininjurymatters.org.uk**

**Or**

**Brain Injury Matters (NI), 5c Stirling House, Castlereagh Business Park, 478 Castlereagh Road, Belfast, BT5 6BQ**

***To be completed by Brain Injury Matters***

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| **Date referral received:** | **Name of recipient:** |
| **Assigned Client code:** | **Appropriate services:** |