‘COUNSELLING SERVICE REFERRAL’ ASSESSMENT FORM

PATIENT NAME		DATE OF BIRTH	
CONTACT NUMBER		GP PRACTICE	

To be completed by the patient

	PLEASE MARK WITH X			
Do you want to learn tools, coping mechanisms, and strategies to manage your low mood, stress, anxiety or depression?	**YES**		**NO**	
	If ‘YES’ ask patient questions below		**If ‘NO’ Book an appointment with a GP**	

ASSESSMENT QUESTIONS	PLEASE MARK WITH X			
Are you waiting for or currently engaging in psychological treatment with the Primary Care Mental Health Team, or any other service?	**YES**		**NO**	
Do you want to work on PTSD, trauma, or an eating disorder?	**YES**		**NO**	
Do you have psychosis i.e. hearing voices etc.?	**YES**		**NO**	
Are you experiencing any suicidal ideas or thoughts of self-harm?	**YES**		**NO**	
Additional Comment:	**‘YES’ to ANY of the above questions - Patient to be booked an appointment with a GP**		**‘NO’ to ALL of the above questions - Patient to be referred to ‘Healthbox Counselling Service’**	