**REFERRAL FORM**

**Please complete this form fully and return to dmt.minthegap@gmail.com**

**In order to progress your referral, and if you have not already done so, please contact us for a free consultation.**

|  |  |  |
| --- | --- | --- |
| Name: | DOB: | Gender (please tick)  Male Non-Binary  Female Transgender |
| Home Address: | | |
| Home Telephone: | | |
| Mobile Number: | | |

|  |
| --- |
| Diagnosis: |
| Are there any safeguarding issues? Yes/No If yes, please give details: |
| Please provide details of any other agencies you are involved with, if applicable: |

|  |  |
| --- | --- |
| GP Name and Address: | GP Telephone Number: |

Reason for referral

**Please provide us with as much information as possible to enable us to have an understanding as to your concerns and reason for referral (please use separate sheets if required)**

|  |
| --- |
| Please describe the behaviour(s) that concerns you: |
| What do you think is the cause of the behaviour? |
| Please provide us with any other relevant information that we should be aware of (e.g. family changes, events, trauma) |
| What do you hope will happen as a result of receiving support from us? |
| Please tell us any days/times that you are **NOT** able to attend sessions |
| Where did you hear about us? |

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please remember, if you have not already done so, to [book](http://www.thebutterflyroom.org/contact.html) a free consultation call with us via our website contact page to progress your referral.

Sharing of Information

I understand that personal information is held about me. Personal information is made up of basic and additional information - basic information means name, address, gender, date of birth, GP etc. Additional information includes any identified needs you may have and how they may be met. It may include relevant sensitive information such as ethnic origin, religion, mental health, sexual health, offences alleged or committed etc.

Yes, I understand and consent to personal information being held about me

In order to provide you with the best treatment, occasionally we may need to share this information with other services including healthcare and/or education professionals, **this will be discussed with you beforehand**.

Yes, I agree to my basic and/or additional information being shared between services

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_