BRYR Counselling Referral Form

Therapist: _____ **Start Date:**_____

Referral Details			
Name of Referral:		Client ref number *(for office use)*	
Address:			
Email address			
Home telephone no.		Mobile Number for Referral Person:	
Name of Parent / Guardian Contact:		Age & Date of birth for Referral Person:	
Number of Parent/ Guardian:			

Referral Details (if applicable)			
Agency name			
Agency address			
Agency email address			
Agency telephone no.		Agency mobile no.	

Reason for referral at this time?

GP Contact details

Address:

GP Contact No:	GP Name:
Detail any medication you are currently taking	

Have you attended other services or agencies in the past or at present (e.g., counselling services,
psychiatric treatment etc)? *(Please tick)* *Yes* *No*

If "yes" please give details

What type of counselling/support would you like?
(Please tick)

- ☐ Individual Counselling
- ☐ Family/parent Counselling
- ☐ Support Group

Please feel free to attach any other information that you think would be useful for us to know.

Signature		Date	

Where You Should Return Your Form?

Any general queries in relation to counselling or referrals can be made by contacting BRYR:

Tel: 01 8667600
Email:counselling@bryr.ie

Please return referral forms to:
Ballymun Regional Youth Resource Ltd
Attn: Mental Health Administrator
The Reco Central Youth Facility
Sillogue Rd
Ballymun
Dublin 11