**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:

**Please return referral forms to:**

Ballymun Regional Youth Resource Ltd

Attn: Mental Health Administrator

The Reco Central Youth Facility

Sillogue Rd

Ballymun

Dublin 11

*Tel: 01 8667600*

*Email:counselling@bryr.ie*