

Professionals' Referral Form

Large font or screen reader friendly versions of forms are available on request.

Please call us on **020 7267 1321**

Thank you for contacting us about our counselling service. For information on the support we offer, please see our website (<http://brandon-centre.org.uk/counselling/>).

Please complete this form, giving as much information as you can, and email the form to **brandoncentre.counselling@nhs.net**

If anything in the form needs explaining or you need help completing the form, please call Brandon Centre on **020 7267 1321** and a member of staff can go through the form with you. Alternatively, text us on **07520 633477** to request a call-back.

Once we have received your form, we will let you know whether or not the young person has been accepted onto our waiting list. It is possible that someone at Brandon Centre may call you asking for more information about your referral. This is so that we have the necessary information to make sure that the young person is provided with the right kind of support.

Please ensure you update us if you or the young person's contact details change as we will send emails, texts and (in some cases) letters confirming the young person's assessment time and date.

We are only able to offer appointments to people aged 16 - 24 who have a Camden or Islington home address.

Please tick the appropriate box below.

Camden

Islington

*Our waiting list is currently several months long. If the young person is currently 24-years-old, please ask us about the length of our waiting list as we can only offer therapy to people up until their 25th birthday.

*If the young person moves away from Camden/Islington (even if they have been accepted onto our waiting list initially), we unfortunately won't be able to offer therapy with our service.

Need help immediately?

Please note that we are not an emergency service. If you or someone you know needs urgent support please contact your GP or go to the nearest hospital A&E.

Anyone in crisis, including children, or concerned family members can now call 111, choose the mental health option (option 2), and talk to a trained mental health professional.

The line is open 24 hours a day, 7 days a week, 365 days a year.

Young Person's Details

Referral Date: DD / MM /		NHS Number:	
First Name		Surname	
Date of Birth	DD / MM / YYYY	Age*	
Current gender		Gender at birth	
Telephone number		Ethnicity & Sexuality	<i>Categories on final page</i>
Email address			
Borough	Camden <input type="checkbox"/>	Islington <input type="checkbox"/>	
Home Address			
Postcode			
Consent to send letters?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Preferred contact method			
School/College/University		Free school meals?	
GP name & practice:			
Address:			
Telephone:			
Has the young person given consent to contact GP?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Has the young person had support from other services (e.g. CAMHS, iCope)	Yes <input type="checkbox"/>	Name of service:	No <input type="checkbox"/>
Has the young person given consent to contact other services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Has the young person or family had support from Social Services?	Yes <input type="checkbox"/>	Name of service:	No <input type="checkbox"/>
Has the young person given consent to contact Social Services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is the young person a Looked After Child or Care Leaver?	Looked After Child <input type="checkbox"/>	Care Leaver <input type="checkbox"/>	

Referral Type		Referred <input type="checkbox"/>	Self-referred <input type="checkbox"/>
REFERRED BY	Name	Telephone	
	Organization	Address	
	Email		
Is the young person aware of this referral?		Yes <input type="checkbox"/>	No <input type="checkbox"/>

Clinical Information

Reason for therapy.

Risk assessment and safeguarding concerns.

Clinical Information

Please provide details of any risk management plans that would be in place if this young person were to be placed on our waiting list.

At point of referral, we may consider other services that might be more suited to this young person's needs or may have a shorter waiting time. If referring from another mental health service please give details of what your service has offered this young person including why she/he cannot be seen at your service and why you think she/he should be seen at Brandon Centre.

Your ethnic group <i>(Please choose one of the following)</i>		
<input type="checkbox"/> Any other ethnic group Please state _____ <input type="checkbox"/> Prefer not to say. <input type="checkbox"/> Unknown	White <input type="checkbox"/> White British <input type="checkbox"/> White Irish <input type="checkbox"/> Any other white background	Mixed <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Any other mixed background
Asian/Asian British <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian background	Black/Black British <input type="checkbox"/> Black Caribbean <input type="checkbox"/> Black African <input type="checkbox"/> Black British <input type="checkbox"/> Any other black background	Chinese or other <input type="checkbox"/> Chinese <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Any other _____

Your Sexuality <i>(Please choose one of the following)</i>		
Heterosexual/ Straight <input type="checkbox"/> Other: _____	Gay/ Lesbian <input type="checkbox"/> Prefer not to say	Bisexual <input type="checkbox"/>