

**The Sanctuary Project**

REFERRAL FORM

Has this referral been completed jointly with the client? Yes/No

(if no, please ensure you do this and explain we offer mental health support)

**Name of client:**

Address:

Client’s Telephone number: Home: Work:

Date of birth:

Sex Female/Male/Trans/Other

Country of origin:

First Language:

Other languages spoken fluently:

Is an interpreter required? Yes/No

If so, which language?

(If an interpreter is required, you will need to find funding for this as we only provide treatment in English)

Approximate date of arrival in the UK:

Does this person live with a carer (eg. if under 18)? If so please supply any relevant information:

Does this person have a social worker and has this referral been discussed with them? Yes/No

(If no, please inform the social worker concerned)

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Name of referrer:

 Practice/Agency/Organisation address:

 Your Telephone number:

 Date of referral:

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GP’s name and address:

Have you informed the GP? Yes(Y) No(N)

Is this client in touch with any of the refugee community groups?:Y/N

If yes, provide name and address of the group:

Is this client involved with any other mental health agencies for these problems? If so, please include as much detail as you can including primary contact. (eg. Local NHS Mental Health Team, Mind Counselling Service, Other Psychological Service including Psychiatrist):

Reason for referral (describe in full the difficulties of the client)

Feeling very sad Tick ( )

Finding it hard to stop thinking about past problems ( )

Feeling very lonely ( )

Wanting to keep away from other people ( )

Getting angry very easy ( )

Feeling scared ( )

Problems falling asleep ( )

Waking up a lot in the night ( )

Nightmares ( )

Finding it hard to concentrate ( )

Not remembering things ( )

Other – please detail:

Is there any risk of harm to the client themselves, or a risk of harm to others? Any history of violence?

Duration of the problem:

What medication has been prescribed?:

(please include dose if known)

Relevant psychiatric, social or medical history in UK or in previous country of residence:

Any other comments:

Signed:

Date referral received:

Referral received by:

Once completed please return this form to:

sally@brightonandhovecbt.com

If you are unsure of any details or wish to discuss please call 07961 779010