ST VINCENT'S HOSPITAL, FAIRVIEW

Clinical Psychology Service

Referral Form for Clinical Psychology

Client's Name: _____ **DOB:** _____

Address: _____ **Telephone:**

_____ **(Home)** _____

_____ **(Mobile)** _____

G.P.: _____

Reason for Referral:(Please include Relevant Reports/Case Summary)

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Current Medication:

_____

_____

Details of Past Psychological Intervention:

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cont/d…..

Please list any Risk Factors (re: Self Harm/History of Violence etc.)

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_____

Referred by: _____ **Sector Team:** _____

Hospital Referral ☐ **Clinic Referral** ☐

Date of Referral:_____ **Contact No:** _____

Please complete form in full and return to:

The Secretary
Psychology Department
St Vincent's Hospital
Convent Avenue
Richmond Road
Fairview
Dublin 3

Telephone: **884 2453**
Fax: **837 0801**
Email: **fyve@svhf.ie**

Office Use Only

Date Ref. Rec.:_____