PSYCHOTHERAPY SERVICE
St Vincent's Hospital,
193 Richmond Road, Fairview, Dublin 3.
Tel: 8842418

REFERRAL FORM

Please include a case summary

Client's Name:_____ DOB:_____

Address:_____ Home tel.:_____

_____ Work tel.:_____

_____ Mobile tel._____

Is this client's first presentation to the mental health services? Yes ☐ No ☐

Has the client consented to this referral: Yes ☐ No ☐

Mode of therapy requested: Individual ☐ Couples ☐ Family ☐ Group ☐

Current psychosocial stressors

_____

_____

Past psychosocial stressors

_____

_____

Please note that this service operates under the Children First Guidelines which stipulate that any current risk of CSA be reported to the relevant authorities.

Does this client have a history of CSA? Yes ☐ No ☐

Has it been reported? Yes ☐ No ☐

Please indicate Axis 1 diagnosis(es)/ICD codes (NO NUMBER PLEASE)

_____

Please indicate Axis II diagnosis(es)/ ICD codes (NO NUMBERS)

_____

Does client have a history of violence or aggression: Yes ☐ No ☐

Describe:_____

Is there a legal case pending: Yes ☐ No ☐

Describe:_____

What other agencies/professionals is client(s) currently attending?

_____

Has the person had psychotherapy previously? Yes ☐ No ☐

Where/with whom/when?_____

_____

What has prompted the referral for psychotherapy at this time?:

_____

_____

Describe the issue/problem to be addressed in psychotherapy?

_____

_____

Severity of client's distress Mild ☐ Moderate ☐ Severe ☐

Impact on client's functioning Mild ☐ Moderate ☐ Severe ☐

Duration of problem/issue < 3 months ☐ 3-6 months ☐ 6-12 months ☐ > 1 year ☐

Please describe any special needs of the client that require accommodation:

_____

Client's sector team: _____

Has this referral been discussed with the sector team? Yes ☐ No ☐

Referrer's name: _____

Address: _____

_____

Tel No.: _____

Date of referral: _____

Please ensure that all items are completed, a case summary is enclosed and that the form is legible.
Referrals that are not complete and cannot be processed, will be returned.