Referral Form

Client Information

SECTION 1: REFERRAL DETAILS	Yes	No
1. Is this a self-referral? (If yes, skip to section 3)		

SECTION 2: REFERRER INFORMATION	
Name of Referrer:	Relationship: i.e. parent, friend, social worker, GP etc.
Organisation: If applicable	
Phone:	Email:

SECTION 3: CLIENT INFORMATION		
Full Name:	Date of Birth:	
Phone:	Email:	
Address:		Postcode:
Emergency Contact: Add their name and number here		

SECTION 4: REASON FOR REFERRAL
Why do you feel you need art psychotherapy?

SECTION 5: SYMPTOMS									
Please put an X to the ones that apply to you or add in 'other'									
	Anxiety		Trauma		Grief and loss		Body Image issues	Other	
	Depression		Loneliness		Low self-esteem		Autism / ADHD		

SECTION 6: ADDITIONAL DETAILS	Yes	No
1. Are you on medication for your mental health?		
2. Do you speak fluent English?		
3. Do you wish to apply for the Accessibility Scheme?		

SECTION 7: HOW DID YOU HEAR ABOUT US?

By signing and submitting this form, I confirm that I consent for my information to be shared with Art Psychotherapy Pathway for the purpose of receiving therapy, in accordance with GDPR regulations.

Client Signature: _____ Date: _____

Referrer Signature: _____ Date: _____

Please return to: art.therapypathway@outlook.com