

## Referral Form for Counselling (Self-Referral)

### Client Details

<b>Name:</b>	<b>Date of birth:</b>
<b>Address:</b>	<b>Home telephone:</b>  <b>Mobile telephone:</b>  <b>Email:</b>
If or when contacting you may we leave a message?  <div style="display: flex; justify-content: space-between;"> <span><b>Landline Yes / No</b></span> <span><b>Mobile Yes / No</b></span> </div> <b>Email: Yes / No</b>	
<b>GP Details:</b> Name: Address: Telephone Number:	
Do you have a cancer diagnosis? <b>Yes / No</b> If no, are you: Carer/Family/Friend <input type="checkbox"/> Bereaved <input type="checkbox"/>  Relationship to the person who has cancer:	
<b>Please complete the following section if appropriate:</b>	
What is your/the person with cancer's diagnosis?	
How might the counselling service help you?	
Do you have any special requirements you feel that we need to know about? (eg mobility, communication) <b>Yes / No</b> If yes, please specify:	
<b>Counselling:</b> Face to face <input type="checkbox"/> Phone <input type="checkbox"/> Online <input type="checkbox"/> No preference <input type="checkbox"/>	
Are you currently being seen by other Health Professionals for emotional or Mental Health support? <b>Yes / No</b>  If yes, please tell us who they are:	

Is there any other information that might help us to support you?

**Client Consent**

I agree to Cancer Focus Northern Ireland contacting me for the purpose of discussing my referral and setting up appointments.

Name (please print): \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please complete and forward to:-**

**Counselling referrals**  
**Cancer Focus Northern Ireland**  
**40-44 Eglantine Avenue**  
**Belfast, BT9 6DX**  
**028 9066 3281**

**For further information:**  
[www.cancerfocusni.org](http://www.cancerfocusni.org)

**If you would like to complete this form online:**

[cancerfocusni.org/counsellingreferral](http://cancerfocusni.org/counsellingreferral)

**If you would like to complete this form with a mobile device:**

