

Please tick any of the following that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Family Illness | <input type="checkbox"/> Sexual Abuse/ assault |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Family separation/ divorce | <input type="checkbox"/> Sexual identity issues |
| <input type="checkbox"/> Behaviour | <input type="checkbox"/> Health (physical) | <input type="checkbox"/> Sleeping difficulties |
| <input type="checkbox"/> Bereavement/loss | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Problems due to 'the Troubles) | <input type="checkbox"/> Social need (housing/ finance) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Problems with friends | <input type="checkbox"/> Suicidal thoughts/ behaviours (self) |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Relationship difficulties | <input type="checkbox"/> Suicidal thoughts/ behaviours (others) |
| <input type="checkbox"/> Eating Issues | <input type="checkbox"/> Self-harm | <input type="checkbox"/> Substance Abuse/ addictions |
| <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Self worth/ self esteem | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Other (not stated) | <input type="checkbox"/> Assertion | |

Please tick if you are asking for help for yourself ☐ Help for someone else ☐

Client signature.....

Name:

Date

Organisation:

.....

Tel No:

Referrals cannot be processed unless all the above information is completed.

Please sign and return the Referral Form to the appropriate address at the top of the form marked "Private and Confidential" and for the attention of Denise Grahame, 50 Regent Street, Newtownards, Co Down, BT23 4LP.

Alternatively, email the Referral Form to info@Cbtcounsellingservices.com as a confidential attachment.



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