**COUNSELLING SELF REFERRAL FORM**

**Please complete all the information requested and return to:**

**counselling@bucksmind.org.uk**

**If you would prefer to post your referral, please send it to:**

**Buckinghamshire Mind, 260 Desborough Road, High Wycombe, Bucks, HP 11 2QR.**

|  |  |
| --- | --- |
| **Title** |  |
| **Full Name** |  |
| **Address** |  |
| **Postcode** |  |
| **Telephone**  |  |
| **Email**  |  |
| **Date of Birth** |  |
| **GP Details** |  |

|  |  |
| --- | --- |
| **Is it ok to say ‘Buckinghamshire Mind if we call or leave a message** | Yes [ ]  No [ ]  |

**Please tick/click box service required:**

* Adult Service (Initial assessment £30, followed by £30 per session) [ ]
* Adult FREE SERVICE (please note, evidence of eligibility will be required **)**  **[ ]**

**Please tick/click box for preferred method(s) for sessions**

* **[ ]** Face to Face
* [ ]  Online (via a Link)
* [ ]  Telephone
* [ ]  Unsure

**Please tick/click box for your preferred time(s) for an appointment? Please tick below:**

* [ ]  Mon – Fri (9am to 12noon)
* [ ]  Mon - Fri (12noon to 6pm**)**

**What is/are the main reason(s) for your referral:**

**1.**

**2.**

**3.**

*Once we receive your referral, a member of staff will contact you via email with further information. Once we receive all the required documents, you will be placed on our waiting list for an initial assessment until we have an available time slot to offer you.*

For more information, please visit[www.bucksmind.org.uk/online-counselling-service](http://www.bucksmind.org.uk/online-counselling-service)

**How did you hear about our service (please highlight or underline)**

GP Friend relative Re referral Healthy Minds Search engine NHS mental health service Other

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