**Self-Referral for Therapeutic Support**

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| Request for support and consent to information storage | | | | |
| 1. I agree to my information being recorded concerning any child/children and family members involved and I understand this information will be used to support our family. 2. I understand this information may be shared on a need-to-know basis with other professionals outside Dunmanway FRC in order to support my family. 3. I understand that this is a voluntary support that I can stop at any time. 4. I understand that if there are any concerns about the safety and welfare of a child, or any vulnerable person, DFRC workers must follow the children First National Guidelines and legislation to protect that individual. | | | | |
| Care Giver’s First name: | Surname: | Relationship to child: | Signature: | Date: |
| Contact Details of Caregiver to be contacted | Mobile No. | Email: |  |  |
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| **Details of the person receiving therapy:** | | | | | |
| Surname: | |  | | | |
| First Name: | |  | | | |
| Date of Birth: | | ............./.............../........... Day Month Year | | | |
| Gender: | | Male □ | | Female □ Non Binary □ | |
| Present Address: | |  | | | |
| Telephone: | |  | | | |
| Email: | |  | | | |
| **Family household composition (children or parents):** | | | | | |
|  | | **Name:** | | **Date of birth** | **Relationship to referred client:** |
| 1. | |  | |  |  |
| 2. | |  | |  |  |
| 3. | |  | |  |  |
| 4. | |  | |  |  |
| 5. | |  | |  |  |

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| **Reason for the therapy request and any relevant information needed?**  **(Please describe the difficulties or issues you'd like support with, e.g., anxiety, depression, trauma, relationship difficulties.)** |
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| **Have you received therapy or mental health support before? If yes, please give details (when, type of support, etc.):** |
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| **Therapy Preference:**  **Please Circle** |
| **Art Therapy**  **Play Therapy**  **Talk Therapy/Counselling**  **Unsure yet** |

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| **Is there anything else you would like us to know?** |
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| **Therapy is provided at a low cost (roughly €50 per session), if you require further cost subsidies please indicate below the cost affordable to you.** |
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| **Internal use only** | | | |
| Date received by relevant service Coordinator: ................................................. | | | |
| Has the referral been accepted? | | | |
| Yes | No | | |
|  | Please give reason why: | | |
| Recommendation and follow up action taken: | | | |
|  | | | |
| DFRC Case Identifier Number | | DFRC /25 | |
| Case allocated to Family support worker: | |  | |
| Signature: | | | |
| Coordinator..................................................... | | | Date................................................. |