**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................................................. |