**Referral for Relationship Counselling**

Please note, sections 1-3 are to be completed by one partner in the partnership, and sections 4-6 to be completed by the other. Please complete sections 7 and 8 together.

1. **Personal Details – Partner 1**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title: |  | Male or Female: |  | Date  of Birth: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | Preferred first name: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First line of Address: |  | Village/Town: | |  |
| City/County: |  | Post Code: | |  |
| Home Telephone: |  | Mobile Telephone: | |  |
| Email Address: |  | | | |
| Marital Status: |  | Dependents: |  | |

1. **Referral Information – Partner 1**

|  |  |  |  |
| --- | --- | --- | --- |
| Have you seen a therapist or coach before? |  | If yes, when and for what reason? |  |
| Reason for this referral: |  | What do you hope to gain from Tilia Therapy? |  |
| How will you know that you no longer require therapy? |  | | |
| GP Name: |  | GP Address and Contact No.: |  |

1. **Medical History – Partner 1**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have a current mental health diagnosis? |  | Are you currently on medication for mental health condition? |  |
| Have you ever attempted suicide? |  | If yes, what is the current risk? | Low  Medium  High |
| Are there any other current or historical medical concerns to be aware of? |  | | |

**4. Personal Details – Partner 2**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title: |  | Male or Female: |  | Date  of Birth: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | Preferred first name: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First line of Address: |  | Village/Town: | |  |
| City/County: |  | Post Code: | |  |
| Home Telephone: |  | Mobile Telephone: | |  |
| Email Address: |  | | | |
| Marital Status: |  | Dependents: |  | |

**5. Referral Information – Partner 2**

|  |  |  |  |
| --- | --- | --- | --- |
| Have you seen a therapist or coach before? |  | If yes, when and for what reason? |  |
| Reason for this referral: |  | What do you hope to gain from Tilia Therapy? |  |
| How will you know that you no longer require therapy? |  | | |
| GP Name: |  | GP Address and Contact No.: |  |

**6. Medical History – Partner 2**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have a current mental health diagnosis? |  | Are you currently on medication for mental health condition? |  |
| Have you ever attempted suicide? |  | If yes, what is the current risk? | Low  Medium  High |
| Are there any other current or historical medical concerns to be aware of? |  | | |

**7. Practicalities of Meeting**

|  |  |
| --- | --- |
| When are you able to meet? (Days and times) |  |
| Preferred mode for meeting?  (face-to-face – please include location, email, zoom) |  |
| Is there anything else to consider or make known before the counselling  begins? |  |
| Do you have any questions before we begin? |  |
| Where did you hear about Tilia therapy? |  |

**8. Declaration**

I confirm that the information given on this form is true, complete and accurate.

Name (Person 1):       Date:

Signature:        (Tick box in place of signature if sent digitally. The authenticity of the signature is confirmed by the email address from which the referral form is sent from).

Name (Person 2):       Date:

Signature:        (Tick box in place of signature if sent digitally. The authenticity of the signature is confirmed by the email address from which the referral form is sent from).