DANCE MOVEMENT PSYCHOTHERAPY

NEW CLIENT REFERRAL FORM

DANCE MOVEMENT PSYCHOTHERAPY REFERRAL FORM

Please complete in as much detail as possible, providing supporting reports and assessments where available

Client details

Surname .....

First name(s) .....

Date of Birth .....

Please specify type of residence (eg. residential care home) .....

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Address .....

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Home Telephone number ……..

Mobile Phone number ……..

Email address ……..

Referrer details

Name .....

Position.....

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Organisation .....

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Address .....

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Telephone number .....

Email address .....

Is the client a parent? Y / N

Client support network

Name .....

Position .....

Address

.....

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Tel no .....

Email .....

Name .....

Position .....

Address .....

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Tel no .....

Email .....

Is the client aware of this referral? Y / N

Are the parents / foster carers aware of this referral? Y / N

Parent/Carer Details (if appropriate)

Parent/Carer name ……

Address

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Tel no ……

Email ……

Parent/Carer name ……

Address (if different) ……

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Tel no ……

Email ……

Reason for referral

Do you have a learning disability, please indicate it below, including any information you feel would help our working relationship in the sessions.

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please tell us any other relevant information on verbal / non-verbal communication skills

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Areas of other needs

Please tell us about any other relevant diagnoses (eg. autism; epilepsy; downs syndrome; physical or sensory disability...)

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GP Details

Name ……..

Address .....

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Tel no ……

Email .....

Details of any <u>current</u> medications: ……

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Mental health

Are there any indications that any of the following apply to the client?

Please circle:

Depression Self-harm ADHD Anxieties/phobias

Sleep disorders Behavioural Issues Dementia

Other Details (eg. any other psychiatric diagnoses) ……

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Is there any history of mental health problems or learning disability in the family? Yes / No

Details ……

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Does the client present with any significant patterns of behavioural issues? Yes / No

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Other behavioural issues

Details: ……

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Referral requirements

I am unable to take a referral unless two areas of responsibility are clarified: support for the client(s) and financial responsibility for treatment.

This form will be returned to you if this page is left unsigned.

Support for (client name) ……

This section is to be signed by the person responsible for the referral of a

client to Lynnette King

I agree to the following:

- ¥ The client/s is/are escorted to and from the therapy
- ¥ The escort will remain on the therapy premises for the duration of the client's session
- ¥ The client/s will be supported in arriving punctually for their session
- ¥ Drivers accompanying the escort and client/s will be known to the referrer, and adequate checks will have been undertaken
- ¥ No escort is allowed to enter the consulting room unless expressly invited by me, the therapist
- ¥ Requests for advice and/or information should be made over the telephone and/or in writing
- ¥ The escort will be over the age of 18
- ¥ The escort will not be accompanied by other clients or family members

Signature: ……

Name in capitals: ……..

Date: .....

Position: .....

Financial Responsibility

The fee for each session is £45.00

At least 2 working days is required, should you wish to cancel/reschedule your appointment.

Failure to do so, will result in you being required to pay the full sessional fee.

Please provide below details of who this contract should be sent to:

Name in capitals Position: ……

Address .....

.....

.....

Postcode .....

Tel ……

Fax .....

Email .....