

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

Client details

Surname First name(s)

Date of Birth Gender

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

.....

Address

.....

.....

Tel no Email

Referrer details

Name Position

Organisation

Address

.....

.....

Tel no Email

Is the client a parent? Y / N

Client support network

Name Position

Address

.....

Tel no Email

Name Position

Address

.....

Tel no Email

Client support network (continued)

Name Position

Address

.....

Tel no Email

Name Position

Address

.....

Tel no Email

Is the client aware of this referral? Y / N

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

Details of birth family

Mother's name

Address

.....

.....

Tel no Email

Father's name

Address (if different from mother's)

.....

.....

Tel no Email

Names and dates of birth of siblings

.....

.....

.....

.....

.....

Ethnic Background

Please tick the box that best describes the client's ethnic origin

- Bangladeshi
- Black African
- Black Caribbean
- Black Other (please specify)
- Chinese
- Indian
- Irish
- Pakistani
- White
- Other (please specify)

First Language:

Other means of communicating:

.....

Reason for referral

Reason for referral (continued)

Level of learning disability

Please tick the relevant box

borderline

mild

moderate

severe

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

Areas of other needs

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

GP Details

Name

Address

.....

Tel no Email

Details of any medication

.....

.....

Mental health

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

	Yes	No	Don't Know
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxieties/phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details (eg. any other psychiatric diagnoses)

.....

.....

Is there any history of mental health problems or learning disability in the family?

Yes No

Details

.....

.....

Please describe any regular employment / daily activities

Behavioural Issues

Does the client present with any significant patterns of behavioural issues (other than sexually abusive behaviour)?

	Yes	No	Don't Know
Inappropriate sexualised behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fighting/aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bullying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damage to property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cruelty to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specified conduct disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details:

.....

.....

	Yes	No	Don't Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other behavioural issues

Details:

.....

.....

Client's History

Please include details of: childhood, schooling, occupation. Please continue on a separate sheet if necessary.

Client's History (continued)

Once the following page has been completed and signed,
please return the form to:

Respond
24 - 32 Stephenson Way
London NW1 2HD
admin@respond.org.uk
fax: 020 7387 1222

Referral requirements

RESPOND is 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 RESPOND.

I agree to the following:

- The client/s is/are escorted to and from RESPOND
- The escort will remain on RESPOND premises for the duration of the client’s session
- Escorts will be sensitive to the sometimes traumatic effects of psychotherapy or Risk Assessment before or after a 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 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 Date

.....
Name in capitals Position

Financial Responsibility / Contract

A contract outlining the service to be delivered will be sent out for signing and returning before the commencement of any treatment / assessment.

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

.....
Name in capitals Position

Funding Authority

Address

.....

..... Postcode

Tel Fax

email

Please tell us how you heard about RESPOND

.....