Wellbeing/Counselling Professional Form

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| Referral Criteria: | * People being referred live in Devon or Torbay.
* People have long term sight loss which can’t be corrected with glasses (not necessarily certifiable).
* People are seeking counselling primarily because of, or because of issues resulting from sight loss.
* People with known drug/alcohol addictions are not suitable for this service.
* Where people don’t meet these criteria we will endeavour to refer people to other counselling services.

People’s eligibility will be assessed by our Emotional Support Coordinator as part of the initial 1 hour Feeling Well, Keeping Well call. |
| Referrer Details: |  |
| Referral Date: |  |
| Referrer Name: |  |
| Role/Organisation: |  |
| Telephone: |  |
| Email: |  |
| Has the client given verbal consent for you to give us their contact details and for us to contact them: (verbal) |

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| Clients Details |
| Surname: |  |
| Forename(s): |  |
| Preferred to be known as: |  |
| Title: |  |
| Address 1: |  |
| Address 2: |  |
| Address 3 |  |
| Address 4 Town: |  |
| Address 5 (County): |  |
| Postcode: |  |
| Preferred method of communication: |  |
| Main Telephone No: |  |
| Mobile Telephone No: |  |
| Email Address: |  |
| Date of Birth: |  |
| Sight Loss Registration:  |  |
| Diagnosis / Eye Condition: |  |
| Additional Health and Communication issues: e.g. Dementia, Hearing Loss, Other  |
| Domestic Information:  |
| Actions/ Referrals already made:  |
| Safeguarding: (Any known areas of risk for Counsellors eg risk of falling.) |
| Presenting needs: |
| Additional Notes |

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| **Please return this form to:****Address:** The Office Manager **Splatford Barton** **Kennford** **Exeter EX6 7XY** | **Contact details****E:** enquiries@devoninsight.org.uk**T:** 01392 876 666 |