



Adult CBT Referral

Personal details

Name:	
Address:	
D.O.B:	
Date of referral:	
Age:	
Contact Number:	
Sex: male <input type="checkbox"/> female <input type="checkbox"/>	
Ethnicity:	Religion:

1. State of health

<p>Has there been any mental health diagnosis?</p> <p>No:</p> <p>Yes:</p>
<p>Please state if you have been diagnosed or currently having any other mental health treatment</p> <p>No:</p> <p>Yes:</p>
<p>Is your GP aware?</p> <p>No:</p> <p>Yes:</p>
<p>Have there been any series of self-harming or suicidal events?</p> <p>No</p> <p>Yes, if so please state:</p>
<p>Please confirm any medication that you are taking:</p>

2. Reason for CBT

(Referrers view on why client requires CBT)

<p>What is your concern?</p>
<p>Please state what could be contributing to the problem?</p>
<p>Do you have any goals that you would like to work on?</p>

Client Signature:	Date: