CONFIDENTIAL SELF-REFERRAL OVER 18 ADULT CONTRACT – PRIMARY CARE

This referral is made into The CLD Trust's Talking Therapies. By completing this form or agreeing to a referral you are consenting to your information being processed by The CLD Trust. This information will be used for the purpose of accessing support. Your details will be processed and stored electronically and in a paper file in accordance with the guidance set out in the General Data Protection Regulations (GDPR). Further information about this will be discussed at your first session.

YOUR DETAILS		
NAME:	DOB:	AGE:
GENDER MALE: ☐	FEMALE ☐	OTHER ☐ PREFER NOT TO SAY ☐
ADDRESS		POSTCODE:
EMAIL:	LANDLINE	MOBILE:
PREFERRED METHOD OF CONTACT: TEL: ☐	EMAIL: ☐	LETTER ☐
Please tell us about your concerns and how these are impacting on you		
Is there anything in your life that is helping or making the situation worse?		

RISK:

	YES	NO
Have you ever had suicidal thoughts?	☐	☐
Have you ever attempted to take your own life?	☐	☐
Do you feel you are at risk to yourself or any other person?	☐	☐

Have you, had any previous experience of talking therapies? Yes ☐ No ☐

Details:

ADDITIONAL INFORMATION

Details of any current medication, please state?

Does the patient have a disability, please state?

Do you require disabled access?

GP NAME

ADDRESS