

Self Referral Form — Use this form if you would like to request a service for yourself.
(Please complete all boxes)

Which service you would like to access?	Counselling <input type="checkbox"/> Mentoring <input type="checkbox"/> Group work <input type="checkbox"/> Not sure <input type="checkbox"/>
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Your Details:

Name:		Date of Birth:	DD / MM / YYYY
Address:		Male	<input type="checkbox"/>
		Female	<input type="checkbox"/>
Post Code:		Other	<input type="checkbox"/>

How we contact you?

Landline Number:		Please provide all contact details and state your preferred method of contact.
Mobile Number:		
Email Address:		

Please tick (a), (b), (c) if you do not give permission.	a) leave a message with someone answering my phone	<input type="checkbox"/>
	b) leave a message on my answering machine	<input type="checkbox"/>
	c) send reminders via text message to your mobile	<input type="checkbox"/>

Your GP's Details

GP Name:		Prescribed medication:
Practice Address:		
Practice Tel No:		

Are you currently receiving support from another service? (e.g. psychological/psychiatric services)

Please provide information about any past support from mental health services?

About you

What are your current difficulties?

Have you had any thoughts of suicide in the last three months?

If yes, please give details: (Please note that the One to One Project is not a crisis service. In the event of current thoughts of suicide, please contact Samaritans on 116 123 or the Crisis Team on 0300 790 0371 if you are already a Trust user)

Yes

No

Do you have any difficulties with alcohol and/or non-prescribed drugs?

If yes, please give details:

Yes

No

What would you like to achieve with the support of the One to One Project?

Where did you hear about the service?

Please outline any specific needs which we may have to be aware of:

Language?

Cultural?

Access?

Disability?

Other?

Please return this form to:

By post

One to One Project, Nelson House, Bergen Way, King's Lynn, Norfolk. PE30 2DE.

By email

onetooneproject@aol.com

Signed:

Date:

Name: