



Adult Counselling Referral Form

Name		
Contact Details		
Male / Female	Female	
Ethnic Origin	Irish	1st Language Level of Proficiency in English

1. Client Information

- Full Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____
- Email Address: _____
- Preferred Contact Method (Phone/Email): _____

2. Referrer Information (if applicable)

- Name of Referrer: _____
- Relationship to Client: _____
- Organization: _____
- Contact Details (Phone/Email): _____

3. Reason for Referral

- Main Concern/Presenting issues:

- Specific areas of support required (tick all that apply):
 - Bereavement Support
 - Trauma Counselling
 - Family or Relationship Issues
 - Mental Health Concerns
 - Stress or Anxiety
 - Other (please specify): _____

4. Background Information

- Duration of concern(s): _____
- Relevant personal or family history regarding your concerns:

- Previous counselling or therapy history:
 Yes No
If yes, please provide details: _____
- Any current or past involvement with Family Resource Centre services?
 Yes No
If yes, please specify: _____

5. Risk and Safety Assessment

- Does the client present any immediate risk to themselves or others?
 Yes No
If yes, please provide details: _____
- History of self-harm or suicidal ideation:
 Yes No
If yes, please provide details: _____
- Any additional safeguarding concerns (e.g., domestic violence, child protection):

6. Consent to Referral

I confirm that the client has been informed about this referral and consents to their information being shared with the Family Resource Centre for the purpose of accessing counselling services.

- Client Signature: _____ Date: _____
- Referrer Signature (if applicable): _____ Date: _____

Please return to

By post coordinator , Mohill FSC, Canon Hall, Mohill ,Co Leitrim

Or email coordinator@mohillfsc.info