Mapesbury Clinic
Counselling for people in exile

Mapesbury Clinic, 20 Lonsdale Road, Queen's Park, London NW6 6RD

Mapesbury Clinic

Referral / Assessment Form

N.B:-

This referral/assessment form has two parts- Part 1 & Part 2. Part 1 is to be completed by referring agency or for self – referral but Part 2 is to be completed by clinical assessor of the clinic and it is not attached here.

Date of Referral:	**Date of Assessment:**
Referring Agency:	**Assessor:**
Funding Agency:	**Date of Allocation:**
Client ID:	**Therapist:**

PART 1:

Client Background Information		
Name:	**D.O.B:**	**AGE:**
Address: **Post Code:** **BOROUGH:**	**GENDER/IDENTITY:** Female ☐ Male ☐ Transgender ☐ Other ☐ Prefer not to say ☐	

SEXUALITY:

Bisexual	
Gay Man	
Heterosexual	
Lesbian	
Other	
Prefer not to say	

TELEPHONE/MOBILE CONTACT DETAILS

Can we leave message?

Tel Home:	Yes ☐	No ☐
Tel Work:	Yes ☐	No ☐
Tel Mobile:	Yes ☐	No ☐

Tel: 020-7644-6250 Fax: 020-7644-6241
E-mail: clinic@minstercentre.org.uk Website: www.mapesburyclinic.org.uk

Next of kin:	**Relationship:**
Address:	Contact Numbers: Home: Work:
Post Code:	Other contacts:

General Practitioner (GP):	Address:
Telephone number:	Post Code:

Demographic Details:	**Country of Origin:**	**Ethnic Background:**
	Which languages do you speak?	Any English? Yes ☐ No ☐
	RELIGION/BELIEF :	
Marital Status:	Single ☐ Married ☐ Separated ☐ Cohabiting ☐ No Children ☐	
Employment Status:	Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Other ☐ Benefits ☐ NASS ☐	
Immigration Status:		Number of years in UK:

1. Status Issues.
Are there any problems with your status that concern you?

2. Housing: Homeless ☐ Rented ☐ Owner ☐ Temporary Accommodation ☐ Other ☐
Are there any problems with your housing that concern you?

3. Health Problems / Issues: Physical ☐ Emotional ☐ Alcohol / Drug ☐ Other ☐
Please give details:

4. DEAF & DISABLED (√)	
Blind & Visual Impairment ☐	**Mobility** ☐
Deaf or Hearing Impairment ☐	**Other Disability** ☐
Learning Difficulty ☐	**Prefer not to say** ☐
Mental Health ☐	

5. Emotional Health Problems.
Have you had any prior contact with counselling/psychiatric services or with a GP for emotional/psychiatric problems? Yes ☐ No ☐ If Yes, what was the reason and treatment you received.
Diagnosis/Medication and Dosage:

6. Family Structure:

Family Member (FM)	Alive/Deceased/Left	Current Age or at time of (FM) Death or Leaving	Client's Age when (FM) Left or Died
Mother			
Father			
Step Father/Mother			
Child 1			
Child 2			
Child 3			
Brother/Sister 1			
Brother/Sister 2			
Brother/Sister 3			
Other(like Carer)			

Signature: ______________________________ Date: ______________________

END OF PART 1