Primary Care Counselling Network

SELF REFERRAL FORM

Name:

Date of birth:

Address:

Post Code:

Contact telephone number: ……

Email address: ……

How would you prefer for us to contact you about an appointment?

……

Please tick all of the session options you will be happy with:

- ☐ Telephone
- ☐ WhatsApp call or video
- ☐ Zoom or Skype
- ☐ Face to face

Please tell us briefly about the problem:

THIS FORM CAN BE DROPPED OFF AT YOUR SURGERY RECEPTION OR YOU CAN ADDRESS IT CONFIDENTIALLY TO THE PRIMARY CARE COUNSELLING NETWORK C/O ST OSWALD'S SURGERY, PEMBROKE SA71 4LD. ALTERNATIVELY PLEASE EMAIL TO: info@pccn.org.uk

Have you accessed a similar service before? (Psychotherapy, specialist counselling services, CMHT). YES/NO

Date: Signed: