Self-referral and Consent form

**Self-referral information**

Name: ……………………………………………………………

Date of self-referral: ……………………………………………………………

Date of birth: ……………………………………………………………

Contact telephone number: ……………………………………………………………

Contact email: ……………………………………………………………

Address: ……………………………………………………………………..…………

|  |  |
| --- | --- |
| Reasons for seeking Art Therapy |  |
| Is any other support currently being provided? Please describe.  |  |
| Please give name and contact details for key worker or lead clinician or other professional currently involved in your care  |  |
| Has any other support been provided previously? Please describe.  |  |
| Please give name and contact details for your GP (this would only be used in case of urgent need/risk) |  |
| Please give name and contact details for your next of kin (this would only be used in case of urgent need/risk) |  |

**Consent**

Please sign below to confirm that you have been given verbal or written information about the art therapy process and issues of privacy and confidentiality, information sharing and record-keeping/access, that you understand the information and give consent to receiving art therapy.

Signature: …………………………………….………………………

Print name: ……………………………………………………………

Date: ……………………………………………………………