**Data Protection Act 2018**

Personal data collected by Mind in Enfield will be used for administrative purposes. This will be stored securely in electronic format on an external server held by the University of York. If you are not suitable for treatment with Mind in Enfield your details will be passed to a provider more suitable and your assessment notes may be passed to them as well.

**Please tick to agree to this statement ☐**

**CLIENT DETAILS**

Title: Title Forename: Enter information

Middle Name: Enter information Surname: Enter information

D.O.B.: Click to enter a date NHS Number: Enter information

**CLINICAL INFORMATION**

Referral Date: 16/07/20 Referral Time: 15:47

Have you previously used an IAPT Service before? Please select If Yes, When? Click to enter a date

If Yes, Please also give a brief reason for what the Counselling was for?

Enter information

Are you currently using any other Mental Health Services? Please select

If Yes, please state Enter information

GP Surgery: Select a GP Surgery Do you give: Consent for GP access: ☐

GP Name: Enter information

Referred By: Select a Referrer

Main reason for referral: Select a Referral Reason

Further information on reason(s) for referral. Please include if you’ve ever received any mental health diagnoses.

Enter information

**DEMOGRAPHIC INFORMATION**

Address Line 1: Enter information Address Line 2: Enter information

Address Line 3: Enter information Town/City: Enter information

County: Enter information Post Code: Enter information

Home No.: Enter information Do you give: Consent to call ☐ Voicemail Consent ☐

Work No.: Enter information Do you give: Consent to call ☐

Mobile No.: Enter information Do you give: Consent to call ☐ Voicemail Consent ☐ SMS Consent ☐

Email Address: Enter information Do you give: Consent to email ☐

 **OTHER DEMOGRAPHICS**

Ex-British Armed Forces: Select an Option

Accomodation Type: Select an Accommodation Type

Ethnic Origin: Select an Ethnicity Gender: Select a Gender

Main Language: Select a Language Interpreter required ☐

Sexual Orientation: Select a Sexual Orientation Religion: Select a Religion

Disability: Please tick all boxes that relate to you
Behaviour and Emotional ☐ Hearing ☐ Manual Dexterity ☐

Learning Disability ☐ Mobility ☐ Perception of Physical Danger ☐

Personal Care ☐ Progressive Condition ☐ Sight ☐

Speech ☐ (Not Stated) ☐ (None) ☐

(Other) ☐

Physical Restrictions: Select a Physical Restriction

Long Term Conditions: Select a Long Term Condition

**EMERGENCY CONTACT INFORMATION**

Emergency Contact Name: Enter information

Address Line 1: Enter information Address Line 2: Enter information

Address Line 3: Enter information Town/City: Enter information

County: Enter information Post Code: Enter information

Contact No.: Enter information

**AVAILABILITY**

Select your availability below:

Any Time ☐ AM Only ☐ PM Only ☐

Monday ☐ AM ☐ PM ☐
Tuesday ☐ AM ☐ PM ☐
Wednesday ☐ AM ☐ PM ☐
Thursday ☐ AM ☐ PM ☐
Friday ☐ AM ☐ PM ☐

**Thank you for taking an interest in the Mind in Enfield IAPT Counselling Service**

**please send your completed form via email to counselling@mind-in-enfield.org.uk**