Referral to WAVE Counselling

WAVE Counselling provides professional therapeutic services to anyone traumatised, physically injured, or bereaved through the Northern Ireland conflict and those who care for them

Client Details

Name: .....

Address: .....

..... Postcode: .....

DOB: ..... Gender: M ☐ F ☐

Tel: (Home): ..... *Can messages be left? Y/N*

Mobile: .....

Name of parent / guardian (if under 16 years old): .....

Referring to (please tick)

Adult Counselling (25+)	
Youth Counselling (6-25yrs)	
Group Programmes	

WAVE Service

Armagh		Derry / Londonderry	
Belfast		Omagh	
Ballymoney			

REASON(S) FOR COUNSELLING REQUEST ***(Link to Northern Ireland Conflict? Yes/No)***

TRAUMATISED		**BEREAVED**		**INJURED**		**CARER**	

PLEASE EXPAND ON THE AREA(S) TICKED ABOVE, PROVIDING BRIEF DETAILS:

- .....
- .....
- .....
- .....
- .....

Additional Reason(s)?

DISTRESSING MEMORIES		**ANGER**		**SLEEPING DIFFICULTIES**	
STRESS		**ANXIETY**		**LOW MOOD / DEPRESSION**	
BULLYING / INTIMIDATION		**PHYSICAL ABUSE**		**DOMESTIC VIOLENCE**	
SUICIDAL THOUGHTS		**SELF HARM**		**SELF ESTEEM**	
ALCOHOL USE / MISUSE		**DRUG USE / MISUSE**		**RELATIONSHIP DIFFICULTIES**	
PERSONAL / FAMILY ILLNESS		**SEPARATION / DIVORCE**		**FINANCIAL DIFFICULTIES**	
EMOTIONAL ABUSE		**SEXUAL ABUSE**		**OTHER**	

PLEASE EXPAND ON THE AREAS TICKED ABOVE, PROVIDING BRIEF DETAILS:

- .....
- .....
- .....
- .....

What issues do you feel counselling might be able to help with? *Please tick the relevant boxes below*

Communicating:	**Confidence:**
☐ Relating to people one-to-one	☐ Confidence in a group
☐ Relating to people in a group	☐ Self-esteem
☐ Help with talking about trauma /symptoms/feelings	☐ Help addressing feelings of powerlessness

Low Mood:	**Anxiety:**
☐ Building Motivation	☐ Developing Relaxation skills
☐ Help addressing feelings of despair	☐ Managing Stress
☐ Developing a Personal Plan	☐ Reducing Isolation

What would be a good outcome for you? **Any questions?**

- .....
- .....
- .....
- .....
- .....

Any previous counselling undertaken? ***Yes/No*** ***If yes, please provide further details below***

Timeframe: *From:..... To:..... ..* Organisation(s) .....

Number of sessions ..... Was it helpful? Yes/No *(if not, why not?)* .....

.....

Have you previously referred to any WAVE services?: Yes/No

If yes, when and what was your experience? .....

.....

.....

RISK: Are there any prior convictions / current risks we need to be aware of? ***If yes, please detail below including any prior / current risk management plans and any involvement of other agencies (eg. Probation, Social Services)***

- .....
- .....
- .....
- .....
- .....
- .....

Contact & Consent		
Are there any other any other relevant services currently supporting the client (you)? Please detail below		
Agency:		**Consent to Contact Sign & date**
Contact Name:		
Address:		
Tel:		
Notes:		
Agency:		**Consent to Contact Sign & date**
Contact Name:		
Address:		
Tel:		
Notes:		

How did you hear about the service?

.....

Referrer Details

Name: .....

Organisation: .....

Address: .....

Phone: ..... **Email:** .....

Please tick if you are requesting help for yourself ☐

Client Signature: ..... **Date:** .....

Referrer Signature: ..... **Date:** .....

Source of Referral ***(please tick)***

Health Professional	
Counselling Agency	
GP	
Community Organisation	
Statutory Agency	
Self	
Family	
Parent / Guardian	

Please return this form to:

Project Manager - WAVE Trauma Centre Omagh (18 Holmview Ave, Omagh BT79 0AQ)

Signed forms can be scanned & emailed to g.buchanan@wavetrauma.org

If you would like to discuss this referral please phone (028) 8225 2522