



STRICTLY CONFIDENTIAL

REFERRAL FORM

This form is to help us assess your needs.

Please answer the following questions as fully as you are able to.

All the information you give us will remain confidential to icap.

For tick boxes – just click in the box.

First name:	
Initial	
Surname:	
Date of birth:	
Address:	
Postcode:	
London Borough (if applicable): <i>e.g. Camden, Islington etc.</i>	
Can we write to you at this address?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Email:	
Can email you at this address?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Landline:	
Mobile:	
Is it ok to leave a message	
(a) with someone answering your phone	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) on your answer machine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Best time of day to contact you by phone:	Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Anytime <input type="checkbox"/>
Are you Irish?	No <input type="checkbox"/> Yes - 1 st generation <input type="checkbox"/> Yes - 2 nd generation <input type="checkbox"/>
Where is your place of birth? <i>If you were born in Ireland, please state what county:</i>	
Other (please specify):	
How long have you lived in the UK? (if applicable)	



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Do you have a disability or mobility issues?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If yes, please provide more information:</i>	
Is this your first time to contact ICAP?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If no, please provide more details:</i>	
To protect your confidentiality, please let us know if any of your family members have or are currently attending ICAP:	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If yes, please state name and relationship:</i>	
Your GP's name and address:	
GP phone number:	
Have you had counselling/therapy before?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If yes, please can you tell us where and when?</i>	
Was it helpful?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you seeing or have you ever seen a psychiatrist?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If yes, please can you tell us when and what treatment was recommended?</i>	
Psychiatrist's name:	
Phone:	
Are you on any medication?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If yes, please can you give us details:</i>	



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The next part is a simple tick box questionnaire to help us ensure that we are reaching all sections of the community

Gender	Male <input type="checkbox"/>
	Female <input type="checkbox"/>
What is your ethnic group	
White	British <input type="checkbox"/> Irish <input type="checkbox"/> Gypsy/Irish traveller <input type="checkbox"/> Any other white background, please give more details below
Asian/Asian British	Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Chinese <input type="checkbox"/> Any other Asian background, please give more details below
Mixed/multi ethnic groups	White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Any other mixed/multiple ethnic background: please give more details below
Black/African/Caribbean/Black British	African <input type="checkbox"/> Caribbean <input type="checkbox"/> Any other black/African/Caribbean background, please give more details below
Any other ethnic group	Arab <input type="checkbox"/> Any other ethnic group, please give more details below

Employment	Working full-time <input type="checkbox"/>
	Working part-time <input type="checkbox"/>
	Unemployed <input type="checkbox"/>
	Retired/pension <input type="checkbox"/>
	Student <input type="checkbox"/>
	Carer <input type="checkbox"/>
	Full-time Parent <input type="checkbox"/>
	Long term sick/disabled <input type="checkbox"/>
	Other <input type="checkbox"/>
	<i>Please state</i>
	Benefits <input type="checkbox"/>



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If on benefits please give more details:	
Sexual orientation	Heterosexual/straight <input type="checkbox"/> Gay Woman/lesbian <input type="checkbox"/> Gay Man <input type="checkbox"/> Bisexual <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to say <input type="checkbox"/>
Personal status	Single <input type="checkbox"/> Co-habiting <input type="checkbox"/> Married/civil partnership <input type="checkbox"/> Widowed <input type="checkbox"/>
Education	GCSE/O Levels <input type="checkbox"/> Irish Inter. Cert/Junior Cert <input type="checkbox"/> A/AS levels <input type="checkbox"/> Irish Leaving Cert <input type="checkbox"/> Degree <input type="checkbox"/> Professional qualifications <input type="checkbox"/> <i>e.g teaching, nursing, accountancy etc.</i> No qualifications <input type="checkbox"/>

Thank you for filling in this form.

For London and Nationwide referrals please return it by email to clinicaladmin@icap.org.uk or by post to:

icap, 96 Moray Road, London, N4 3LA

For West Midlands referrals please return it by email to info@icapbirmingham.org.uk or by post to:
icap, 72 Digbeth, Birmingham, B5 6DH