MdC MUSIC THERAPY
Music dedicated to Connection.
Music devoted to Change.

REFERRAL FORM

(CONFIDENTIAL)

MdC Music Therapy
London, UK
info@mdcmusictherapy.com
www.mdcmusictherapy.com

Please fill out and email to referrals@mdcmusictherapy.com. If you are filling out this form for someone else, you must ensure that they are aware and that you discuss the reasons for referral with the person or with their official carer. Please include as much information as possible.

CLIENT DETAILS

Surname:	Forename:
Date of birth (DD/MM/YYYY):	Gender (if prefer to say):
NHS No. / ID No. (if applicable):	Ethnicity (if prefer to say):
Main contact number:	Occupation:
Address:	Email address:
First language:	Interpreter needed? Y / N

DETAILS OF CARER (if applicable)

Full Name of Parent / Carer:	Relationship to client:
First language:	Interpreter needed? Y / N
Address:	Main contact number:
Email address:	

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REFERRER'S DETAILS (IF SELF-REFERRED PLEASE LEAVE BLANK)

Name of Referrer:	Organisation & Designation:
Relationship to client:	Date of referral:
Address:	Main contact number:
Email address:	

REASONS FOR REFERRAL TO MUSIC THERAPY

Please describe any presenting issues, including severity, duration, and impact:

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PERSONAL / FAMILY HISTORY

Please outline any relevant personal and family history particularly around mental illness or trauma:

HISTORY OF TREATMENT

Please outline any previous treatment or interventions:

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MEDICAL / MENTAL HEALTH HISTORY

Please list any official diagnoses or pending physical or mental health investigations:

GENERAL PRACTIONER	**SCHOOL** (if applicable)
Name:	Name:
Address:	Address:
Contact number:	Contact number:
Consent to contact GP?: Y / N	Consent to contact school?: Y / N
Mental Health Care Plan? Y / N *Care Plan Manager & Details:*	Extra education support? Y / N *If yes, what level?*
	Education, Health and Care Plan (EHCP)? Y / N *Details:*

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OTHER MAIN PROFESSIONALS INVOLVED IN CARE (if applicable)

1. Name:	2. Name:
Role:	Role:
Address:	Address:
Contact:	Contact:
Consent to contact: Y / N	Consent to contact: Y / N
Care Plans / Contracts / Regularity of Contact? *Details:*	Care Plans / Contracts / Regularity of Contact? *Details:*

OTHER SIGNIFICANT CONCERNS OR RISKS

Please let us know if there are any other concerns or any history or potential of risk:

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CONSENT	
Has the client agreed to this referral?	YES / NO
Has / have the client's parent(s) / carer(s) agreed to this referral?	YES / NO / N/A

DECLARATIONS - REFERRER	
Referrer's Name:	Referrer's Designation:
Team Name / Organisation:	Contact number:
Address:	**Signature:**

FOR OFFICIAL USE ONLY	
Referral received by:	Date received:
Date of first consultation:	Date of first treatment:
Notes:	
Actions:	**Signature:**