

DONEGAL COUNSELLING CENTRE

CONFIDENTIAL REFERRAL FORM

Request counselling support

Please complete this short form before an appointment can be offered. The Centre will review it and contact you to discuss availability and suitability.

YOUR DETAILS

Preferred name

Full name

Date of birth

Phone number

Email address

Town / area

Pronouns (optional)

CONTACT PREFERENCES

☐ Phone call

☐ Text message

☐ Email

REASON FOR REFERRAL

Please briefly tell us what you would like support with

Who is completing this form?

☐ I am referring myself

☐ Parent / guardian

☐ Professional

If someone else is completing it, please give their name, role and phone/email

Preferred format

☐ In person

☐ Online

☐ Either

CONSENT

☐ I consent to the Centre contacting me and securely storing this referral for review.

Signature (type full name if completing electronically)

Date

RETURNING YOUR FORM

Save the completed PDF and email it to referrals@donegalcounsellingcentre.ie.

A follow-up intake call will be arranged. Sending this form does not guarantee an appointment.

Not monitored for emergencies. In immediate danger, call 112 or 999.