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**Self-referral and Consent form**

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| **Date of self-referral** |
| **Name** |
| **Date of birth** |
| **Contact telephone** |
| **Contact email** |
| **Address** |
| **Next of kin / emergency contact** |

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| **Reasons for seeking Art Therapy** |
| **Please give name and contact details for key worker or lead clinician or other professional currently involved in your care** |
| **Have you received any support previously? Please describe.** |
| **Please give name and contact details for your GP**. (With your permission we will notify your GP that you are receiving art therapy. Should we have serious concerns about your safety we would contact your GP). |

**Consent**

Please sign below to confirm that you have been given verbal or written information about the art therapy process, including privacy and confidentiality, information sharing and record-keeping/access.

I understand the information and give consent to receiving art therapy.

**Signature**

**Date**