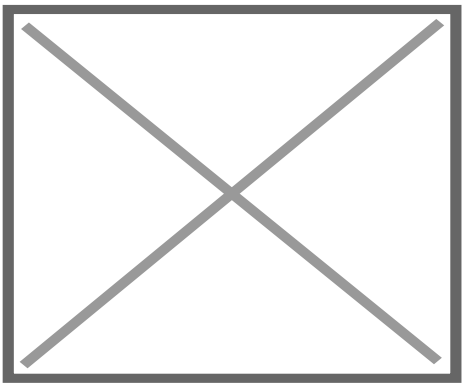
Partner Referral (ABS)

Description



Name(Required)

First Last

Address(Required)

Street Address Address Line 2

City ZIP / Postal Code

United Kingdom ▼ Country

Email(Required)

A summary of your assessment and recommendations will be sent to this email address.

Phone (mobile preferred)(Required)

Date of birth(Required)

Anxiety UK services are for those aged 18+ only

DD slash MM slash YYYY

Reference Number(Required)

We require your ABS reference to process your request or write 'STAFF' if you are an ABS staff member.

GP surgery details (inc. phone number)(Required)

Please tell us in a few words why you wish to access therapy(Required)

I am eligible to access Anxiety UKâ??s therapy services, and confirm the following:(Required)

☐ I am seeking support for anxiety/an anxiety disorder

☐ I agree to be always registered with a GP & give permission for an Anxiety UK Approved Therapist to contact my GP if there are concerns for my own, or othersâ?? safety.

☐ I have not had active thoughts of suicide in the last six months

☐ I have not been a mental health inpatient in the last six months

- ☐ I have not been under the care of mental health crisis services in the last six months
- ☐ I do not have a substance use issue that would affect my ability to meaningfully engage with therapy
- ☐ I have not received a diagnosis of bipolar disorder, schizophrenia or psychosis
- ☐ I do not have a complex emotional need/personality disorder
- ☐ I am not currently receiving talking therapy
- ☐ I agree to have my camera on (for online therapy only)

If you are unable to check all boxes, we may request further information from you.

Tell us about your availability

Please inform us of your unavailable times, please note that some requests may delay access to support

Please confirm to proceed:(Required)

- ☐ I accept Anxiety UK's terms and conditions

I consent to receive marketing & fundraising emails from Anxiety UK(Required)

- ☐ Yes
- ☐ No

CAPTCHA

Submit