GALWAY MUSIC THERAPY

Galway Music Therapy Referral Form

NAME……..... Date of birth……..

Address …….. Next of Kin……..

……. Tel/mob No……..

……..

Referred by…… Tel No……..

Relationship to client/patient…….

Reason for Referral

Brief Medical History

Other relevant information
(e.g. history of epilepsy, diabetes, sensory impairment, challenging behaviour, self harm).

Other professional involvement (e.g. psychologist, speech therapy, physiotherapy, key worker)

What is the current life situation of client/patient?.....

Funding source (private, health service, education, social services, charity, grant etc)

Number of sessions contracted…….