University College Dublin Student Counselling Service
2017-2018

Welcome to the UCD Student Counselling Service. Please read the information leaflet overleaf and then complete and sign this brief Registration Form. All information collected will be treated in a confidential manner.

Name:	**Student No:**
Ok to contact by E-Mail : ☐ **Yes** ☐ **No**	**Date of Birth (DD/MM/YY):** _____/ _____/_____
Term Contact Address: **Ok to contact by post?** ☐ **Yes** ☐ **No**	**Home/Permanent Address** (if different from term address): **Ok to contact by post?** ☐ **Yes** ☐ **No**
Mobile Phone No:	**Ok to contact to call/text?** ☐ **Yes** ☐ **No**
Details of person to contact in case of emergency (Name, Address, Phone No, Relationship, e.g. parent)**:**	
Family GP Details (Name, Address, Phone No.)**:**	

Nationality:	**Type of current accommodation** (please tick)**:** ☐ Family Home ☐ UCD Campus Residences ☐ Private Rented Accommodation ☐ Other (Please specify):	
Course What course are you studying? What year of the course are you in?	**Registered as** (please tick): ☐ Undergraduate ☐ Post Graduate Masters ☐ Post Graduate Doctorate ☐ Other (Please Specify):	**Are you registered as /with any of the following?** (Please tick if relevant) ☐ UCD Disability Service ☐ HEAR ☐ Mature Student ☐ International Student

Are you currently attending a Psychiatrist ☐ Yes ☐ No If yes, ☐ UCD Psychiatrist ☐ Other Psychiatrist

Are you currently attending counselling/psychotherapy elsewhere ☐ Yes ☐ No

Source of Referral (please tick)**:**

- ☐ Self
- ☐ Student Health Service GP
- ☐ Student Health Nurse
- ☐ Student Health Psychiatrist
- ☐ Own family GP or Medical Specialist
- ☐ Academic Staff at University
- ☐ University Chaplain
- ☐ Student Adviser
- ☐ Disability Service Staff
- ☐ Student Welfare Officer
- ☐ Any other Staff member at the University
- ☐ Other (please specify):

Student Consent: I have read the ***UCD Student Counselling Service: Information for Students Considering Counselling*** leaflet and accept that I am attending the Student Counselling Service on this basis.

Signature:______________________________ Date of Registration: (DD/MM/YY) ____/ ____ /____

For Office Use Only

Date Referral Received:	(DD/MM/YY)	___/ ___/ ___	
Date of First Appointment Offered:	(DD/MM/YY)	___/ ___/ ___	
Date of First Appointment Accepted:	(DD/MM/YY)	___/ ___/ ___	Time: ___:___ With (initials):
Type of Appointment (please tick) S ☐ **D** ☐ **P** ☐			