CHESHIRE TRAUMA THERAPY
THE PAIN LAB

Referral Form – EMDR Pain Service

Client Information	
Name	
DOB	
Address	
Telephone	
Email	
Emergency Contact Name	
Relationship to you	
Emergency Contact Tel	
GP Name and Contact	

Referring details – Professional who is completing this form on behalf of client	
Name of Referrer	
Organisation	
Telephone	
Email	
Reference No.	

Reason for Referral
Please include the reason for referral The Pain Lab psychological team, including details of psychological symptoms and pain condition (if you have exact medical and/or psychological diagnosis from medical expert or NHS team please include this).

Details of Treatment Authorisation	
Please give details of any prior approval you have received for treatment at this time	
Initial Assessment plus Treatment Report	☐
1-1 EMDR treatment sessions	☐
If treatment sessions have been approved please indicate here how many have been authorised	

Agreement	
I confirm that prior to referring my client to this service that I have the necessary funding required to facilitate full payment within 30 days of completion of the service.	☐
Print Name	
Signed	
Dated	