# University College Dublin Student Counselling Service
# 2012-2013

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.

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

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

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

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| ☐ Self | ☐ University Chaplain |
| ☐ Student Health Service GP | ☐ Student Adviser |
| ☐ Student Health Nurse | ☐ Disability Service Staff |
| ☐ Student Health Psychiatrist | ☐ Student Welfare Officer |
| ☐ Own family GP or Medical Specialist | ☐ Any other Staff member at the University |
| ☐ Academic Staff at 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**

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| 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** ☐ | | | | |