

Turtle Spring Arts, Limited



Art Therapy Centre

2 Rhine Street (off Murray Street)

Island Bay, Wellington

Phone 04-387-2303

Cell Phone: 021 872 303

Email: maryb@actrix.co.nz

www.compassion.org.nz

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Dear Professional Care Provider,

WELLINGTON'S FIRST SPECIALISED ART THERAPY CENTRE OPENS IN ISLAND BAY FOR YOUR BENEFIT

I am opening a child and family focused practice in Island Bay and would like to introduce myself and my specialist skills to you. I am a counsellor/ therapist with thirteen years experience working with children and families through community agencies, the Public Health System and private practice.

I have postgraduate clinical training in Art Therapy from the U.S. and specialist professional training in Play Therapy and Interactive Drawing Therapy. Art therapists help clients to restore health and balance to the mind and body through the structured use of art materials. Art and Play Therapy is an alternative to talking therapy and effectively supports clients to deal with emotional and behavioural problems.

I offer Play and Art Therapy, Family Counselling and Group Art Therapy at the **Art Therapy Centre**. The **Art Therapy Centre** is a purpose built facility designed for running adult and child groups and has a therapeutic playroom for school age children. It is located in the previous hospital building at the Home of Compassion, generously renovated for this purpose by the Sisters.

I welcome referrals by phone, email or post. A referral form is attached below. Clients may self refer directly by phoning 04 387-2303 or by cell phone 021 872-303.

Call me now and we can arrange a time for me to meet and discuss further the opportunities my facility means to your clients or contacts.

Warmest Regards,

Mary Brownlow, MFA, BFA

Art Therapist

American Art Therapy Association, Professional Member

Applicant Member NZ Association of Counsellors

REFERRAL		Date of Referral	
Previous Client?		Last Contact?	
Client/Tangata Whaiora Details			
Surname:		Given Names:	
Gender: Female Male		Date of Birth:	
Address: Street Suburb City		Telephone: Home Work Mobile	
Place of Birth:		Occupation/School:	
Ethnicity:		Teacher:	
Client/ Tangata Whaiora			
Primary Carer: (if not parents) Mother: Father:		Others Living at Home name, age, relationship to client	
General Practitioner		Agency/Team Referred By	
Name Address Telephone Fax		Name Address Telephone Fax	
Request		Possible Disorder	Identified Stressors
Reason for referral request e.g. assessment, treatment, in response to		Anxiety/Phobia Depression Mood Disorder Bipolar Schizophrenia Psychosis Post Traumatic Stress ADHD Alcohol/Substance Abuse Other	Primary support group/family/whanau Social environment Ante/post-natal Loss Custody Physical Illness Occupation/School Housing Legal Financial Other
Details			
Other Agencies Involved		Other Health & Disability Information	