

**Sexual Abuse and Incest Line**

**‘Surviving and Thriving’**

**Agency referral for Therapy Service**

* **Please complete this referral form and return it to us at the address at the bottom of this form.**
* **When we receive the referral we will contact the client for an initial mutual assessment.** This is to assess their current needs and to decide if therapy is the right service at this time. If it is, they will then be placed on our waiting list until a counsellor becomes available for weekly counselling sessions. This will be discussed with at assessment. We aim to respond within 2 weeks.

Where did they hear about SAIL?**………………………………………………………………………………………………..**

**Personal Information**

|  |  |
| --- | --- |
| **Their full name:**  **Job title**  **Agency they are referring from**  **Address** |  |

**Which is the best way for us to contact they?** Please circle.

|  |
| --- |
| **Method of contact** |
|  |
| Landline number | Yes/ no  **Ok to leave a message**  Yes/no |
| Mobile number | Yes/ no  **Ok to leave a message**  Yes/no |
| Email address | Yes/ no |
| Letter by post | Yes/ no |

**Please remember to let us know if they change any of their contact details.**

Client information

|  |  |
| --- | --- |
| **GP DETAILS** | **MEDICATION** |
| GP Name:  GP Surgery and GP Address:  GP Contact Number: | **Are they currently being prescribed medication? Please tick all that apply.**  Anti-depressants  Anti-psychotics  Anxiolytics (for anxiety)  Other (please specify)  **…………………………………………………………………………**  **…………………………………………………………………………**  **…………………………………………………………………………**  **…………………………………………………………………………** |

Have they had therapy/counselling with SAIL in the past? **Yes ( ) No ( )**

If yes, how long ago was this? ………………………………………………………………….

**Which of these services have they used previously or are currently using for emotional or psychological support? Please tick all that apply.**

|  |  |  |
| --- | --- | --- |
| **SERVICE** | **CURRENTLY USING** | **USED IN THE PAST** |
| SAIL Support & Advocacy |  |  |
| Counselling / Psychotherapy |  |  |
| Community Mental Health Team(s) |  |  |
| CPN/Psychiatric Care |  |  |
| Psychological Treatment (specialist team) |  |  |
| Hospital admission(s) |  |  |
| Other (please specify) |  |  |

|  |  |
| --- | --- |
| **For current support, please give contact details of any other agencies that the client is engaged with** | **Consent to contact/ share information** |
| **Name of Worker: Contact Number:**  **Role of Worker:**  **Agency:** | Yes/ no |
| **Name of Worker: Contact Number:**  **Role of Worker:**  **Agency:** | Yes/ no |

**Do they consider they have a disability? YES ( ) NO ( )**

If yes, please state below and let us know how SAIL can accommodate their needs?

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

**Please note that SAIL is not able to provide creche or child care facilities.**

**Assessment - This is a one off appointment before they start counselling. The person who assesses them may not be their therapist.**

**Therapy**

**Are they available to attend regular weekly appointments on:**

Please tick all that apply

AM - Monday Tuesday Wednesday Thursday Friday

PM - Monday Tuesday Wednesday Thursday Friday

**Please tick the issues which they have experienced/are experiencing:**

Domestic abuse Sexual domestic abuse

Sexual abuse Exploitation

Raped as an adult Childhood sexual abuse

Childhood sexual exploitation Non sexual child abuse

Suicide attempt Increased Suicidal thoughts

Self-harm Alcohol abuse

Substance Misuse Mental health

**Please tell us the reason for the therapy referral at this time?**

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**The following questions help us to make sure that we provide the best service for all our users and don’t discriminate against any section of our community.**

**Gender:**

Female Male Trans-woman Trans-man Other (please specify) …………………………………………………………………….

**Marital Status**

Single Married Separated Divorced

Civil partnership Divorced Widow/Widower In a relationship

**Additional information**

**Who do they live with? Please tick as many boxes as appropriate**

Live alone Other relatives/friends

Partner Parents/guardian

Living in shared accommodation Lliving in temporary accommodation,

Living in hospital/ organisation Homeless – contact centre, point of contact

Other (Please specify):

**Pregnancy, maternity and caring**

Pregnant Caring for children under 5 years

Caring for children under 6 months Caring for children over 5 years

Other caring responsibilities (Please specify i.e. disabled/elderly):

…………………………………………………………………………………………………………...........

**What is their employment status? Please tick the box that best describes their main occupation**

Employed full time (30 hrs. +) Unemployed

Employed part time Student - full-time

Employed – temporary Student – part-time

Carer Volunteer

Homemaker Retired

Long term sick

**Benefits**

Are they in receipt of any work-related benefits – i.e. statutory sick pay, income support, Employment and support allowance (ESA), Universal Credit, Disability living allowance (DLA) (please specify):

…………………………………………………………………………………………………

**How would they describe their race/ethnicity?**

**White:**

British Irish Gypsy/Traveller/Roma Other White Background (please specify)

…………………………………………………………………………………………………

**Black/African/Caribbean/Black British:**

Caribbean African Black British Other (please specify)

…………………………………………………………………………………………………

**Asian/Asian British:**

Indian Pakistani Bangladeshi Chinese Other (please specify)

………………………………………………………………………………………………….

**Mixed/Multiple Ethnic Group:**

White and Black Caribbean White and Black African White and Asian Other Mixed Background (please specify) ………………………………………………………………………………………………...

**Other Ethnic Group:**

Arab Any other ethnic group (please specify) Not known

………………………………………………………………………………………………….

**How would they describe their religion/belief?**

None Christian Islam Judaism Buddhism Hinduism Sikhism Prefer not to say Other (please specify) …………………………………………………….

**Which of the following describes their sexual orientation?**

Heterosexual/straight Lesbian/Gay Bisexual Other Prefer not to say

**Are they affected by any of the following?**

Refugee/Asylum seeker Fleeing abuse Pregnant

**What is their main language?**

English Other (including sign languages) please specify…………………………………………………………

**Data Protection Act 2018**

**The personal data collected on this form will be kept secure and confidential within SAIL. Personal data will only be used for client support and monitoring within SAIL. This information will never be disclosed to any external sources without their express written consent.**

**SAIL does share anonymised and unidentifiable information with funders in support of our work.**

To comply with the Data Protection Act it is essential that they give their consent by signing below. I give my permission for SAIL to hold the information given on this form about myself

Signature..................................................................................

Date..........................................................................................

**If they are signing this form on behalf of someone else, please sign here with details**

Signature ………………………………………………………….

Date ……………………………………………………………….,.

Details ………………………………………………………………

**How well can they speak English?**

Very well Well Not well Not at all

Thank they for completing this form.

Please return to SAIL Administrator

[Elaine.eyre@sailderbyshire.org.uk](mailto:Elaine.eyre@sailderbyshire.org.uk)

FOA of Elaine Eyre

SAIL, 12 Soresby St, Chesterfield, Derbyshire, S40 1

We will acknowledge receipt of the completed form within two weeks.

|  |
| --- |
| **Office use only**  Referral Complete  Missing information |