**Please complete all fields with a \* to ensure we can process the referral.**

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| **Referrer details (if applicable)**  |
| \*Agency and worker name: |
| **Personal Details** |
| \*Full name:  |
| Also known as:  |
| \*Date of Birth:  |
| \*Phone number: \*Is it safe to call? **Yes** [ ]  **No** [ ] \*Can we leave a voicemail? **Yes** [ ]  **No** [ ] \*Can we send a text? **Yes** [ ]  **No** [ ]  | Email: \*Can we send an email? **Yes** [ ]  **No** [ ]  |
| Preferred contact method: Choose an item. |
| \*Address: \*Postcode:  |
| \*Can we send information to this address? **Yes** [ ]  **No** [ ]  |
| **We request the following information for the purpose of helping our staff use the most respectful language when addressing you, in addition to understanding our client demographics better and fulfilling our grant reporting requirements. Please help us serve you better by providing answers to the following questions.** Religion: Choose an item. If ‘other’ please state:\*Ethnic group/background: Choose an item. If ‘other’ please state:\*Gender identity: Choose an item. If ‘other’ please state: \*Sexual/Romantic Orientation: Choose an item. If ‘other’ please state:Preferred pronoun: Choose an item. If ‘other’ please state:  |
| **Reason for Referral: (example; bereavement, anxiety, relationship, work, debt)** |
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| **Medical Details (Statutory Field)** |
| **We will not disclose to your GP or your lead professional the context of your counselling support. However, in terms of safeguarding and managing risk we do have a duty of care to multi agency work and in these circumstances, we will contact your lead professional/GP.** **We would make every effort to support you to speak with your lead professional/GP first.**  |
| \*Doctor's Name: \*Practice: Address: Postcode: |
| \*Do you consider yourself to have a disability? Yes [ ]  No [ ] \*If yes please provide details including any reasonable adjustments required:  |
| \*Have you received any mental health diagnosis from your GP or any other mental health professional? **Yes** [ ]  **No** [ ]   |
| \*Please provide details of any mental health conditions/diagnosis: |
| \*Please provide details of any medications including names & doses:   |
| \*Are you currently receiving any psychological therapy, counselling or mental health support? **Yes** [ ]  **No** [ ]  \*If yes please provide details: **Please note that we cannot offer counselling if a client is engaged elsewhere or is receiving other therapy such as CBT, DBT or EMDR. If a client is on a waitlist elsewhere please contact us to discuss.**  |
| \*Please state if you have experienced any of the following in the last month: |
| Suicidal plan in place  |[ ]  Self-harm |[ ]
| Taking steps to end life | [ ]  | Harm related to substance/alcohol use  | [ ]  |
| \*If any of the above boxes are ticked please provide details:  |
| **What happens next**  |
| 1. Once your referral has been received one of our SPOC’s [single point of contact] will confirm receipt with both the referrer (if applicable) and client, usually via email.
2. We will place the client on the waitlist for the most appropriate counselling centre based on the details provided on this referral. We may speak with the client and request further information at this stage to ensure we can provide you with appropriate support, signposting you elsewhere if needed.
3. We will send the client information forms which will explain the support available and provide a waitlist guideline, answering any questions they may have.
 |
| **Availability for Weekly sessions:**  |
|  | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
| AM |  |  |  |  |  |
| PM |  |  |  |  |  |
| **How would you like to access our services:** |
| Face to Face [ ]  Telephone [ ]  Video [ ]  |
| **Consent** |
| **I consent to the information I have provided being processed and stored by the You Counselling Centres (part of The You Trust) in order to provide me with counselling services.**  |

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| **SIGNATURE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**We cannot process this referral without your consent.** | **Date:**  |
| **Permission to share to nominated individual (ie partner/parent etc..:****Name of nominated individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Your Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

A copy of the YOU Trust’s Data Protection Policy can be provided on request.

For ALL referrals please send to youcounselling@theyoutrust.org.uk