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

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| **Referrer details (if applicable)** | |
| \*Recovery Worker name: | |
| \*Service/Project: | |
| **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:  \* If address cannot be provided please confirm if client is living in a safe house/refuge:  **Yes  No** | |
| \*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:  \*Gender at Birth: 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** | |
| \***Please briefly indicate the reason for referral, e.g. family dynamics, work issues, depression. Please state if the referral is being made for recent/historic sexual or domestic violence and provide information regarding ongoing abuse if applicable.** | |

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| **Disclosures (Sexual Violence Referrals Only)** | | | | |
| \*Has the person being referred ever committed or been investigated for committing any sexual offence? **Yes  No**  (If yes please give details of offence/year/sentence/repeat offences): | | | | |
| **Medical Details** | | | | |
| **We will not disclose to your GP that you are having counselling support. Your GP would only be contacted if we believed we needed to take direct action due to a risk to your health. We would make every effort to support you to speak with your GP yourself first.** | | | | |
| **\*GP Details**  \*GP Name:  \*Practice:  Address:  Postcode: | | | | |
| \***Emergency contact**  \*Name:  \*Contact number: | | | | |
| \*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: | | | | |
| **Where Would You Like to Meet Your Counsellor? (Substance Misuse Referrals Only)** | | | | |
| **Existing Community Day Rehab Client** | | | **The Community Day Rehab** (*Mornings and early afternoons)* | |
| **The Recovery Hub** (*Tuesday and Thursday evenings from 5pm-7pm)* | | | **Focus Point, Kingston Crescent** (*Daytime sessions Mon-Friday until 6pm)* | |
| **Remote** (Online or telephone) | | | | |
| Any accessibility requirements? | | | | |
| **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. 4. STAR (Sexual Trauma and Recovery) Counselling Centre clients may be offered a place in a psychoeducational groupwhilst they are waiting to be allocated for a 1:1 session with a counsellor. | | | | |
| **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:** | **Date:** |

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](mailto:youcounselling@theyoutrust.org.uk)

*If you are unsure please send to any email address, we will confirm which counselling centre the referral has been processed under when confirming receipt.*