**Sexual Abuse and Incest Line**

**'Surviving and Thriving'**

Self-referral for Therapy Service

**Please complete this referral form and return it to us at the address at the bottom of this form.**

***To be completed by person requesting therapy*** If you have any questions, or need help completing this form, please either contact us on 0800 028 2678 or ask someone you know to help you.

**When we receive your referral, we will contact you for an initial assessment.** This is to assess your current needs and to decide if therapy is the right service for you at this time. If it is, you will then be placed on our waiting list until a counsellor becomes available for weekly counselling sessions. This will be discussed with you at assessment. We aim to respond within 2 weeks

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

What is your preference for a male or female counsellor? ……..

What is your preference for telephone/online counselling or face to face counselling?
……..

**Personal Information**

| | |
|---|---|
| **Your full name:**<br>**Any previous name:**<br>**Address**<br><br><br>**Date of Birth** | |

**Can you tell us the best way for us to contact you?** Please circle.

| **Method of contact** | **Ok to Contact** |
|---|---|

| | |
|---|---|
| Landline number | Yes/ no<br>**Ok to leave a message**<br>Yes/no |
| Mobile number | Yes/ no<br>**Ok to leave a message**<br>Yes/no |
| Email address | Yes/ no |
| Letter by post | Yes/ no |

**Please remember to let us know if you change any of your contact details.**



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

| | |
|---|---|
| GP Contact Number: | ……<br>…<br>……<br>…<br>……<br>… |

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

If yes, how long ago was this? ……..

**Which of these services have you 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 | Consent to contact/ share information |
|---|---|
| | |

| | |
|---|---|
| **Name of Worker: Contact Number:**<br><br>**Role of Worker:**<br><br>**Agency:** | Yes/ no |
| **Name of Worker: Contact Number:**<br><br>**Role of Worker:**<br><br>**Agency:** | Yes/ no |

**Do you consider yourself to have a disability?** **YES ( ) NO ( )**



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

……
……
……

Please note that SAIL are not able to provide creche or child care facilities. Please make alternative arrangements for when attending your appointment.

**<u>Assessment</u> - This is a one off appointment before you start counselling. The person who assesses you may not be your therapist.**

**<u>Therapy</u>**

**I am available to attend regular weekly appointments on:**

Please tick all that apply

AM - Monday Tuesday Wednesday Thursday Friday

PM - Monday Tuesday Wednesday Thursday Friday

**Will you be traveling by car or public transport?** ……

**Please tick the issues which you 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 your reason for therapy at this time?**

……
……
……
……
……..

***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

**<u>Additional information</u>**

**Who lives with you? 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 your employment status? Please tick the box that best describes your 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 you in receipt of any work-related benefits – i.e. statutory sick pay, income support, Employment and support allowance (ESA), Disability living allowance (DLA) (please specify):

……

**How would you describe your 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 you describe your religion/belief?**

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

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



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

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

Refugee/Asylum seeker Fleeing abuse Pregnant

**What is your main language?**

**Data Protection Act 2018**

**The personal data collected on this form will be kept secure and confidential within SAIL. Your personal data will only be used for the purpose of client support and monitoring within SAIL. This information will never be disclosed to any external sources without your 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 you give your consent by signing below. I give my permission for SAIL to hold the information given on this form about myself

Signature.....

Date.....

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

Signature …….

Date ……,.

Details ……

English  Other (including sign languages) please specify……

**How well can you speak English?**

Very well Well Not well Not at all

Thank you for completing this form.

Please return to SAIL Administrator

Elaine.eyre@sailderbyshire.org.uk

FOA of Elaine Eyre

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

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

**Office use only:-**
Complete
Missing information