



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 01246 559889 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?.....

Personal Information

Your full name: Any previous name: Address Date of Birth	
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Can you tell us the best way for us to contact you? Please circle.

Method of contact	Ok to 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 you change any of your contact details.

GP DETAILS	MEDICATION
GP Name:	Are you currently being prescribed medication? Please tick all that apply.
GP Surgery and GP Address:	
GP Contact Number:	
	<input type="checkbox"/> Anti-depressants <input type="checkbox"/> Anti-psychotics <input type="checkbox"/> Anxiolytics (for anxiety) <input type="checkbox"/> Other (please specify)

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: Role of Worker: Agency:	Yes/ no
Name of Worker: Contact Number: Role of Worker: 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.

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

Therapy

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:

- | | |
|--------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Domestic abuse | <input type="checkbox"/> Sexual domestic abuse |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Exploitation |
| <input type="checkbox"/> Raped as an adult | <input type="checkbox"/> Childhood sexual abuse |
| <input type="checkbox"/> Childhood sexual exploitation | <input type="checkbox"/> Non sexual child abuse |
| <input type="checkbox"/> Suicide attempt | <input type="checkbox"/> Increased Suicidal thoughts |
| <input type="checkbox"/> Self-harm | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Substance Misuse | <input type="checkbox"/> Mental health |

Please tell us your reason for therapy 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.

Preference for Counsellor

- Female Male Other Preference (please specify)

Preference for Counselling

- Face to Face Therapy Telephone Therapy Zoom/Video Therapy

Gender:

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

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Marital Status

- Single Married Separated Divorced
 Civil partnership Divorced Widow/Widower In a relationship

Additional information

Who lives with you? Please tick as many boxes as appropriate

- Live alone Other relatives/friends
 Partner Parents/guardian

- Living in shared accommodation
- Living in hospital/ organisation
- Other (Please specify):
- Living in temporary accommodation,
- Homeless – contact centre, point of contact

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?

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. 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

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