

**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**  |  |
| --- | --- |

**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:GP Surgery and GP Address: GP Contact Number: | **Are you currently being prescribed medication? Please tick all that apply.**• Anti-depressants• Anti-psychotics• Anxiolytics (for anxiety)• 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:**

• 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.***

**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) …………………………………………………………………….

**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 • 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?**

• 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 • |
| --- |