

Email completed referrals to [Ydtherapeutic.services@yellowdoor.cjsm.net](mailto:Ydtherapeutic.services@yellowdoor.cjsm.net)

**Disclaimer:** Please be aware that your referral has been logged but will not be active until we have received this completed form. All referrals are reviewed and considerations are made as to whether we are the appropriate service.

DATE:

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| **Yellow Door Adult Services Referral (*please see Section 7 for referral guidance prior to completing this referral*)** |

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| **SECTION 1 – CLIENT DETAILS** | | | | | | |
| **Forename** |  | | | | **Surname** |  |
| **Also known as** |  | | | | **Date of Birth** |  |
| **Gender** |  | | | |
| **Address** |  | | | | | **Landline / home telephone number** |
| Client’s first language | | Interpreter required? □ Yes □ No  If yes, which language? | | | | |
| Does the client consider themselves to be transgender?  □ Yes □ No | | Sexual orientation:  □ Heterosexual □ Gay  □ Lesbian □ Bisexual □ Prefer not to say | | | | |
| Does client have a disability?  □ Yes □ No  If Yes, Please specify: | Does the client have a  Visual impairment □ Yes □ No  Hearing impairment □ Yes □ No | | | | | Does the client have any caring responsibilities?  □ Yes □ No |
| **Name of GP** |  | | | | **GP surgery name** |  |
| GP surgery telephone number and email address |  | | | | GP surgery address: |  |
| **Ethnicity** | □ White British | | □ Irish | | | □ Gypsy or Irish Traveller |
| □ White and Black Caribbean | | □ White and Black African | | | □ White and Asian |
| □ Indian | □ Pakistani | | □ Chinese | | | □ Bangladeshi |
| □ Any other Asian background | □ African | | □ Caribbean | | | □ Other Black/Caribbean/African Background |
| □ Arab | □ Any other ethnic group – please state | | | | |  |
|  | □ Any other mixed/multiple ethnic background – please state | | | | |  |
| **Religion** | □ Agnostic □ Atheist □ Baha’I □ Buddhist □ Chinese (Taoist / Confucian)  □ Christian □ Hindu □ Humanist □ Japanese (Shinto) □ Jewish □ Jainism  □ Muslim □ Pagan □ Rastafarian □ Sikh □ Spiritualist  □ Do not wish to disclose □ Other | | | | | |
| **SECTION 2 – CHILDREN’S SERVICES** | | | | | | |
| Names and Dob’s of any children |  | | | | | |
| Name of Allocated Social Worker or Family Support Worker |  | | | | | |
| Children’s Services Team |  | | | | | |
| Address |  | | | | | |
| Telephone |  | | | | | |
| **SECTION 3 – PRESENTING ISSUES, RISK AND CONCERNS** | | | | | | |
| Please state any mental health difficulties, onset, frequency and duration, current presenting risk, details of any self harming behaviours, suicidal ideation/intent, interventions tried, impact on work/education and family, and any relevant medical history: | | | | | | |
| **What services have been accessed already?**  **Is this support ongoing?** | | | | | | |
| **Is the client on any current medication?** □ Yes □ No If Yes, please provide details: | | | | | | |
| **Are there any concerns relating to substance misuse?** □ Yes □ No If Yes, please provide details: | | | | | | |
| **Are there any concerns relating to food/weight/suspected eating disorder?** □ Yes □ No If Yes, please provide details: | | | | | | |
| **SECTION 4 - Reasons for Referral** | | | | | | |
| **Sexual abuse/violence** □ Yes □ No If Yes, please provide details:  **Domestic violence** □ Yes □ No If Yes, please provide details:  Is this ongoing □ Yes □ No If Yes, please provide details: | | | | | | |
| **What is your expectation of what support at Yellow Door might help the client with** | | | | | | |
| **SECTION 5 – REFERRER DETAILS** | | | | | | |
| Name |  | | | Job Title/Profession: | | **ISVA** |
| Address | | | | | | |
| Post Code: | | | | Telephone: | |  |
| Date of Referral |  | | | Email address | |  |
| Are you still offering the client a service □ Yes □ No    If yes what is being offered?  ISVA Support  If no what are the reasons for not offering a service? | | | | | | |
| **SECTION 6 - REFERRAL CONSENT** | | | | | | **If no, please give reason** |
| Does the client know about the referral? | | | Yes | | No |  |
| Does the client consent to the referral? | | | Yes | | No |  |
| Does the client want Yellow Door support | | | Yes | | No |  |
| Preferred method of contact | | | Phone | | Email | Post |
|  | | | | | | |
| **SECTION 7 - REFERRAL GUIDANCE** | | | | | | |
| **Guidance for Referrer's - Yellow Door Therapeutic Services**  YD Therapeutic services offer a range of group interventions and some time limited 1-1 work with clients who have experienced Domestic and Sexual Abuse (DSA). We also offer Family Therapies as well as Prevention, Advocacy, Criminal Justice Support and Diversity and Inclusion services to those who are vulnerable to or impacted by DSA (please see website for further details).  Prior to making a referral to our Therapeutic Service please consider:   * Whether the client has the emotional resilience to engage in a structured therapeutic intervention. * Whether the client’s circumstances are sufficiently stable to support regular and meaningful attendance as well as positive therapeutic outcomes. * Whether the client has Mental Health needs beyond the mild to moderate range that we are able to work with. Please bear in mind that **YD is not resourced to manage significant or chronic risks** such as those relating to ongoing suicidal ideation or to self-injurious behaviours that are severe and/or repeated.   At the point of referral, we can provide estimated waiting times but please be aware that each of our therapy services operate with a waiting list system. Where YD has started therapeutic interventions and a risk profile escalates and/or complexity becomes apparent such that we consider YD interventions to be contra-indicated, we will work with appropriate services to plan transition.  **Yellow Door Therapeutic Interventions for Adults**  **1:1 Counselling**  Counselling is a talking therapy that allows you to discuss any experiences or difficult feelings in a safe, confidential environment. You might come to counselling with specific experiences or events that you would like to talk to someone about or work through, or you may simply want to explore your thoughts and feelings in more depth.  **Safer Relationships Group**  ​This weekly therapeutic group looks at what unhealthy behaviour within relationships can look like, and seeks to establish healthy ways of establishing safe and happy relationships. Group members have the opportunity to share their experiences and assist one another in finding individually appropriate solutions to challenging circumstances.  **Then & Now Group**  This weekly therapeutic group has been developed as a specialist group for adults who experienced sexual abuse in childhood. It offers a safe space to explore thoughts, feelings and experiences in a group setting.  **Trauma Focused Group**  This group is being developed to support adults who have experienced sexual assault and are presenting with recent trauma. It uses psycho-educational techniques to explore our responses to trauma and aid recovery. It will support clients to understand more about the emotional, psychological and physiological reactions to negative and traumatic experiences.  **ECS Group**  This group is available for clients who are struggling with managing feelings and emotions and who are seeking to find ways of better managing their ability to cope in day to day life. | | | | | | |

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| **FOR OFFICE USE ONLY** |
| To be discussed with coordinator □ Yes □ No  To be taken to screening meeting □ Yes □ No  Further information required □ Yes □ No  Request for Info sent □ Yes □ No  **Not appropriate referral for therapeutic services**  Reason…………………………………………………Signposted to………………………………………………………Date……………………  Client notified………………………………….Date………………………………………..  **Additional Internal Support Signposting – requested or suitable for:**  TFT ISVA DIA DAT  Please state if internal support is being offered instead of/as well as Therapuetic Services  **Referral made** □ Yes □ No  Date………………………  **Appropriate referral for therapeutic services** □ Yes □ No  **Manager checked …………………………………………………….. Date………………………………………………………………………………..**  **Circle recommended therapeutic Services Intervention** :  FT FS 1:1 Then & Now ECS Safer Relationships Psychoeducation group  Creative Arts Bright Stars Art Journaling Telephone Support Email Support  **Added to waiting list** □ Yes □ No  **Waiting list email sent Date: ………………………………………………………………….** |