 **Yellow Door Therapeutic Services - Self Referral**

Email completed referrals to servicedelivery@yellowdoor.org.uk with **Self-Referral**

in subject box

**Disclaimer:** Please note this is not a secure email but is checked daily. Yellow Door takes your confidentiality and privacy rights very seriously. We collect, process, transfer and store your personal information under the General Data Protection Regulation (GDPR) 2018. For more information, please see our privacy policy on our website.

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| **Please complete this referral form if you would like to be considered for Group or 1:1 counselling and are an Adult who has had an unwanted sexual experience at any point in their life.****In order to assess if we are the right service for you at this time we require you to complete this as fully as possible.**  |

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| **SECTION 1 – YOUR DETAILS** |
| **Date form completed:**  |
| **First Name:** |  | **Surname:** |  |
| **Also known as:** |  | **Date of Birth:** |  |
| **Address:** |  | **Telephone number:****Email Address:****Preferred contact method:** |
| **Gender:** **□ Female □ Male □ Transgender □ Prefer not to say □ Other, please specify:** |
| **Name of GP:** |  | **GP surgery name:** |  |
| GP surgery telephone number and email address: |  | GP surgery address: |  |
| **In an emergency:**  | Name: |
| Telephone: |
| **SECTION 2 – REASON FOR REFERRAL** |
| **Sexual abuse as an adult** □ Yes □ No If Yes, please provide any details you feel comfortable sharing at this stage:**Sexual abuse as a child (under 18)?** □ Yes □ No If Yes, please provide any details you feel comfortable sharing at this stage:I**s any of the sexual abuse ongoing?** □ Yes □ No If Yes, please provide any details you feel comfortable sharing at this stage:Poli **Have you ever reported any of the incidents above to police**? □ Yes □ No RM Is there an ongoing investigation? □ Yes □ No If Yes, please provide any details Are  Are you considering reporting? □ Yes □ No Would you like support around this? □ Yes □ No  |
| **SECTION 3 – WHAT DO YOU REQUIRE SUPPORT WITH** |
| Please score each issue with how big a problem it is for you. Add any additional information you feel would be helpful for us to know

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|  | **0****Not a problem** | **1****Hardly ever a problem** | **2****Sometimes a problem** | **3****Often a problem** | **4****A big problem** |
| **Low Mood** |  |  |  |  |  |
| **Anxiety** |  |  |  |  |  |
| **Self-Care** |  |  |  |  |  |
| **Self Esteem** |  |  |  |  |  |
| **Food**  |  |  |  |  |  |
| **Alcohol/Drugs** |  |  |  |  |  |
| **Sleeping** |  |  |  |  |  |
| **Relationships** |  |  |  |  |  |
| **Self-Harm** |  |  |  |  |  |
| **Suicidal thoughts** |  |  |  |  |  |

**Have you ever made any suicide attempts Y/N****How many attempts:****When was the last attempt:****What triggered this:****Did you seek help/support:****Do you feel at current risk to yourself or from/to others** □ Yes □ No If Yes, please provide any details you feel comfortable sharing at this stage ……………………………………………………………………………………………………………………………………………………………………………………………..……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… |
| **SECTION 4 – OTHER SERVICES/SUPPORT** |
| **What support services have you accessed already?****Do you currently or have you had any support from psychological or mental health services?** □ Yes □ No If Yes, please provide details:**Is support ongoing** □ Yes □ No If Yes, please provide details:**Name of worker:****Can we contact them?** □ Yes □ No please provide details:**We will need to send an information request to current/previous support in order to consider if we are the right service at this time** |
| **Are you on any medication?** □ Yes □ No If Yes, please provide details: |
| **Do you have any concerns relating to substance misuse?** □ Yes □ No If Yes, please provide details: |
| **Do you have any concerns relating to food/eating?** □ Yes □ No If Yes, please provide details: |
| **Do you have any involvement with Children’s Services?** □ Yes □ No Name of Allocated Social Worker or Family Support Worker:Children’s Services Team:Contact details:Names and Date of birth of any children: |
| **SECTION 5 - What would you like to get from therapy?** |
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| **SECTION 6 - EQUAL ACCESS INFORMATION** |
| **Do you have any difficulties with the following?** Mobility Language Culture/ Community Hearing Sight Travel   Chronic health problemsDo we need to make any adjustments or arrange an interpreter order for you to be able to access our services? □ Yes □ No If Yes, please provide details:……… ……………………………………………………………………………………………………………………………………………………………………….……… ……………………………………………………………………………………………………………………………………………………………………….. |
| **Relationship Status:** | □ Single □ Married / Civil Partnership □ Maternity □ Children □ Prefer not to say □ Other: Please state  |
| **Religion or Religious beliefs:** | □ Agnostic □ Atheist □ Buddhist □ Christian □ Hindu □ Jewish □ Muslim□ Pagan □ Sikh □ Spiritualist □ Do not wish to disclose □ Other **If other, please state:** |
| **Work: Please mark those that apply** | □ Full time work □ Part Time Work □ Unemployed □ Retired□ JSA/ESA/Incapacity Allowance □ Member of Trade Union □ Prefer not to say  |
| **Do you consider yourself to have a disability?**□ Yes □ No □ Prefer not to say**If yes, which of the following apply to you? (you can select more than one)**□ Visual Impairment □ Hearing Impairment □ Sensory Impairment □ Physical Disability □ Learning Disability □ Mental Health Condition□ Long Term Condition □ Other: Please state | **Do you have any caring responsibilities?****□ Yes □ No**If Yes, please specify: |
| **Education: Please mark those that apply**□ Full Time Education □ Part Time Education Attendance: %□ Home Educated □ Not in Education, Training or Employment Attendance: %School or College name:School Year:  |
| **Accommodation: Please mark all those that apply**□ Owned / Rented □ Homeless □ Temporary Accommodation □ Child Looked After □ Refuge□ Asylum Refugee / New to the UK □ Living with family/carer □ Visited by Carer □ Hostel □ Prefer not to say □ Other: Please specify:

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| **Sexual orientation:****□ Heterosexual □ Gay □ Lesbian □ Bisexual □ Prefer not to say □ Other, please specify:** |
| **Ethnicity:** | **□** White British | **□** White European | **□** 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 |  |

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| **SECTION 7 - DISCLOSURES** |
| **Has there been or are there currently any criminal investigations relating to yourself offending in any way?** □ Yes □ No If Yes, please provide details:Y / De ta (year /offence / sentence/ probation) ……………………………………………………………………………………………………………………………….………………………………………………………….…………………………………………………………………………………………………………………………………………….………………………………………………………………………………………………………………………………………………………………………………………… **Have you ever committed, or been investigated for committing any sexual offences?** □ Yes □ No  I f If Yes, please provide details:  (year /offence / sentence/ probation) ……………………………………………………………………………………………………………………………….Details……………………………………………………………………………………………………….………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..etails: |
| **SECTION 8 - REFERRAL GUIDANCE** |
| **Guidance for referrals - Yellow Door Therapeutic Services** YD Therapeutic services offer a range of group interventions and time limited 1-1 work with clients who have experienced Sexual Abuse /Violence. Prior to making your referral to our Therapeutic Service please consider:* Whether you have the emotional resilience to engage in a structured therapeutic intervention. Therapy can be hard work and it is important you are able to cope emotional with talking about difficult things.
* Whether your circumstances are sufficiently stable to support regular and meaningful attendance as well as positive therapeutic outcomes.
* Whether you have Mental Health needs beyond the low to moderate range. Please bear in mind that YD is not resourced to manage significant or high risks such as those relating to ongoing suicidal thoughts or to self-harming 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 your risk escalates and/or complexity becomes apparent such that we consider YD interventions to not be in your best interests, we will work with appropriate services to plan transition. |

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| **FOR OFFICE USE ONLY** |
| To be discussed with coordinator □ Yes □ NoTo be taken to screening meeting □ Yes □ NoFurther information required □ Yes □ NoRequest 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 DATPlease state if internal support is being offered instead of/as well as Therapeutic Services **Referral made** □ Yes □ NoDate……………………… **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: ………………………………………………………………….** |