Please complete the following referral form and return it to claire@srchelp.org.uk. Answers marked with \* are mandatory.

|  |
| --- |
| **Counselling Referral Form** |
| **Client Details** |
| **\*First Name:** | **\*Last Name:**  |
| **\*Preferred Name:** |
| **\*Are you 14 or older? Yes** [ ]  **No** [ ]  |
|  |
| **Contact Details** **(Please provide at least one method of contact)** |
| **Home Telephone:**  | **Call** [ ]  **Voicemail** [ ]  | **Preferred Contact** [ ]  |
| **Mobile Telephone:** | **Call** [ ]  **Text** [ ]  **Voicemail**[ ]  | **Preferred Contact** [ ]  |
| **Address:****Preferred Contact** [ ]  | **Email Address:**  | **Preferred Contact** [ ]  |
| **Preferred Counselling Location** | **Ipswich** **Bury St Edmunds****Lowestoft** |[ ]
|  |  |[ ]
|  |  |[ ]
| **\*Any other contact information:****Our office is on the first floor with no lift. If you have any difficulty getting upstairs, please let us know and we can arrange to meet you in a downstairs room.** |
|  |
| **Equality Monitoring** |
| **\*Date of Birth:** | **\*Gender:**  |
| **Ethnicity:**  | **Disability:**  |
| **Sexual orientation:**  | **Religion or Belief:**  |
|  |
| **Incident Details** |
| **\* Age at presenting incident:**  | **\* Reported to police? Yes** [ ]  **No** [ ]  |
| **Criminal Justice Process:** | **Perpetrator:** |  |  |  |
| **Ongoing** [ ]  **Complete** [ ]  | **Acquaintance****Current Partner** **Ex-Partner** **Family Friend** | [ ] [ ] [ ] [ ]  | **Family Member****Friend****Professional****Stranger** **Other** | [ ] [ ] [ ] [ ] [ ]  |
| **\*Type of Incident: (tick all that apply)**  |
| [ ]  **Child Sexual Abuse** [ ]  **Child Sexual Exploitation**[ ]  **Domestic Violence**[ ]  **Rape** | [ ]  **Sexual Violence** [ ]  **Stalking/Harassment**[ ]  **Other (Please state below)** |
| **Any additional Information:** |
|  |
| **Data Protection** |
| **\*Please note: All information given on this form will be kept and stored in accordance with the new data protection guidelines (GDPR, 2018). The person named on this form can gain access to any of their stored information at any time and can request that any information given be destroyed****.** **\*If you give consent for us to store your information please tick this box** [ ] **\*If you give consent for us to contact you regarding counselling** [ ] **If you would like to join our e-mail mailing list and receive our newsletter containing service updates, fundraising events, volunteer opportunities and employment opportunities please tick here (16+)** [ ]  |
|  |
| **Referring Agency Information:** |
| **Referring Organisation:**  |
| **Contact Name:**  | **Contact Number:**  |
| **Email Address:** | **Agency Ref.:**  |
| **Are we able to contact you regarding this referral? Yes** [ ]  **No** [ ]  |

**………………………………………………………………………………………………………………………………………………………………………………………….**

**\*\*Office use only\*\*
Date Ref received: SRC Code:**