Service Six

Changing Lives • Creating Futures

Service Six

Initial Contact & Referral Form for

Service Six' services

This form is for self-referrals & assisted self-referrals to access Service Six' services. An assisted self-referral is when you have someone who is helping you to complete this form.

The information provided will be used to enable us to offer the most appropriate services and actions will be kept confidential and securely stored and shared as appropriate within Service Six. Confidentiality is central to our work but it is not absolute - there are legitimate exceptions of some circumstances which require Service Six to share information with others, such as; if a person is at risk of serious harm by others; if a person is at risk of serious harm to them self or to others; or there is a risk of serious crime. A copy of our Confidentiality & Data Protection Policy is available on request or can be found on our website www.servicesix.co.uk .

Some information will be used for reporting purposes; in these cases, the data will contain no identifying information that could associate you with receiving a service. Any other information will not be released without your consent unless required by law or a court order as stated above.

We are not able to offer you counselling/therapy if you are seeing another counsellor or psychological therapist, or if you are currently receiving a high level of Mental Health Care. In these cases, we might be able to offer you any other support services which is not counselling. Prior, during or after you receiving a service you can contact Service Six at 01933 277520 or send an email to referrals@servicesix.co.uk for any questions you might have. Please complete the form as fully and accurate as you can.

Name of Person making the Referral		**Contact Details**			
If this is an assisted referral is the person you want to refer aware of this referral?			**Yes** ◯	**No** ◯	
Potential Client Details (Information about You)					
First Name		**Date of Birth**		**Age**	
Surname		**Gender**		**Ethnicity**	
Address incl. Postcode				**Disability** (please specify)	
Please provide client's (your) NHS Number if known (this is required for NHS reporting purpose only)					
If you do not know the client's (your) NHS number, please tick this box to confirm you are happy for us to obtain this on the client's (your) behalf:			**Yes**	☐	
Phone Number		**Email Address**			
Who can we speak to at home re this referral?					
Who can we *NOT* speak to at home re this referral?					
Are we allowed to contact you via (please tick as appropriate)	**Phone** ☐	**Post** ☐	**Text** ☐	**Email** ☐	**Other** (please specify)
Are we allowed to leave a message on your phone?		**Yes** ◯		**No** ◯	
Are you in…?	**Education** ☐	**Training** ☐	**Employment** ☐	**Unemployed** ☐	**Retired** ☐
Other (please state)					

For Family Therapy Referral ONLY
Please provide information about each Family Member

Full Name		**Date of Birth**	
Relationship (i.e sister, step-brother, parent)			
How do the issues affecting this family member?			

Reason for Referral (Information about You and multiple choices possible)

Abuse ☐	**Anger** ☐	**Anxiety** ☐	**Bereavement** ☐	**Depression / Low Mood** ☐	**Domestic Abuse** ☐
Eating Disorder ☐	**Family** ☐	**Low self-esteem** ☐	**OCD** ☐	**Online Grooming** ☐	**Self-harm** ☐
Sleep Difficulties ☐	**Suicidal** ☐	**Trauma/PTSD** ☐	**Violent Behaviour** ☐	**Other, please specify**	

Detailed Reason for the Referral (Information about You and your situation)

Please provide a full explanation for the referral to Service Six. *(where sufficient detail is not provided to warrant a referral, this form may be returned to the referring agency or individual.)*

School Details (for children and young people referrals ONLY)			
Name of School			
Phone Number		**Email**	
School Address incl Postcode			
Is the school aware of this referral? (please tick)		**Yes** ◯	**No** ◯
Are we allowed to contact the school to book a room for your sessions (please tick)		**Yes** ◯	**No** ◯
GP Details (Information about You)			
Name of GP			
Phone Number		**Email** (if available)	
GP Address incl Postcode			
Is your GP aware of this referral? (please tick)		**Yes** ◯	**No** ◯
Are we allowed to contact your GP surgery to book a room for your sessions (please tick)		**Yes** ◯	**No** ◯
Is there an Early Help Assessment (EHA) in place?		**Yes** ◯	**No** ◯
Are there currently any other professionals involved? (please tick)		**Yes** ◯	**No** ◯
If Yes, please can you specify Name and agency			
Are we allowed to contact the above? (please tick)	**Yes** ◯	**No** ◯	**Contact Details Phone Number and/or Email**
If there are any other relevant details you think we should know or be aware of, such as health issues or Disability, please specify below.			

Please save this form and email it to

referrals@servicesix.co.uk

In the interest of security, please ensure that you have the correct spelling of the above email address prior to sending.

Thank you