**Third Party Referral Form**

**Warwickshire Counselling/Therapy Service**

**Please complete all fields**

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| **Welcome to Safeline Warwickshire Counselling/Therapy Services –** We ask that when making a referral for counselling/therapy, both you and the individual on whose behalf you are making this referral take into consideration that **we offer** counselling **to complement a client’s current support system and it should not replace other essential support.**Please share here what on-going support your service is offering the individual on whose behalf you are making this referral. |
| **Named contact(s) involved in individual’s care: Contact no:**  |
| **Referring Agency/Organisation Name:** **Email:**  | **Form completed by:** **Telephone No:** **Date Completed:**  |
| **Client’s Full Name:**  | **Client’s Address and Postcode:****Is it okay to contact via post: Y / N** |
| **Date of Birth:** |
| **Email Address:** **Is it okay to contact via email: Y / N** |
| **Contact Tel number:****Is it okay to call this number: Y / N****Is it okay to leave a voicemail: Y / N** |

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| ***Additional information for funding purposes - if you would prefer not to say then please leave blank*** |
| **Gender:** | **Sexuality:** | **Ethnicity:**  |

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| **What is the preferred method of contact: Phone / Email / Post** |
| **GP Name & Address** | **Does the individual you are referring have a disability we should be aware of? (Physical, Learning, Mental Health)****[ ] Prefer not to say** |
| **Other Agencies/Orgs/Health prof involved?** **Please include contact details:** |
| **Has the client ever been aggressive or violent towards another professional? If yes, please give details:** |
| **Client’s reasons for referral to Safeline:** *(Please* *continue on separate sheet if necessary)***Please note: This service is for children, young** **people and adults aged 5+ living in Warwickshire, who have experienced sexual abuse,** **rape or sexual violence and for those who support them.*****When did the sexual abuse/violence occur******? As a child Y/N* [ ]  *As an adult Y/N*[ ]** ***Has the client had counselling with Safeline before******? Y/N If yes, when did this finish? …………………..******Would the client consider seeing a student counsellor? Y/N******Please indicate the client’s preference of counsellor gender: No preference Male Female******If we are able to offer counselling, this may be face to face, online or telephone.*****Counselling Sessions**Counselling takes place at the same time and day each week. Flexibility in the client’s availability for counselling may enable us to arrange the client’s counselling sooner, however if there are any days of the week that they are unable to attend counselling, please tell us below. |
| **Is the client (& if applicable, an accompanying person) able to climb stairs? Y/N** |
| **Would you like Safeline to contact the client? Y/N** | **Please return to e-mail: office@safeline.org.uk****Safeline, 6a New Street, Warwick****CV34 4RX****Tel: 01926 402498****Website:** [**www.safeline.org.uk**](http://www.safeline.org.uk) |
| **Does Safeline have the client’s permission to contact them? Y/N**  |
| *By submitting this form, you are giving consent to Safeline to store and process your personal information in line with the General Data Protection Regulation (GDPR) 2018.* |