Specialist Psychotherapy, Counselling & Support Service
Uplands House, 5 Lichfield Road, Walsall WS4 2HT
☎ Tel: 01922 722777 🖷 Fax: 01922 721110
therapy@crisispoint.org.uk www.crisispoint.org.uk

REFERRAL FORM

1. **COMPLETE ALL SECTIONS,**
2. **WRITE "UNKNOWN" OR "NOT APPLICABLE", IF INFORMATION IS NOT AVAILABLE OR SECTION IS NOT RELEVANT**

Client / Service User Details

Surname:		Previous surname:	
Forename:		Preferred name:	
Date of Birth:	Age:	Telephone Contact No: *(safe to use)* :	E-mail *(if available)* :
Permanent address: Postcode:		Current address *(if different to permanent address)*: Postcode:	

Ethnic Origin

Tick relevant box

- ☐ White British
- ☐ Black or Black British - Caribbean
- ☐ Black or Black British - African
- ☐ Other Black background
- ☐ Asian or Asian British - Indian
- ☐ Asian or Asian British - Pakistani
- ☐ Asian or Asian British - Bangladeshi
- ☐ Chinese
- ☐ Other Asian background
- ☐ Mixed – White & Black Caribbean
- ☐ Mixed – White & Black African
- ☐ Mixed – White & Asian
- ☐ Other Mixed background
- ☐ Other Ethnic Background – specify below

  _____

- ☐ Information refused

Gender

Tick relevant box

- ☐ Female
- ☐ Male

Sexuality

Tick relevant box

- ☐ Heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Transgender/ Transexual/Intersex
- ☐ Information refused

Physical / Learning Difficulties

Tick relevant box

- ☐ No known disability
- ☐ A specific learning difficulty, e.g. Dyslexia
- ☐ Blind/Partially Sighted
- ☐ Deaf/Hearing Impairment
- ☐ Wheelchair User/Mobility Difficulties
- ☐ Personal Care Support
- ☐ Mental Health Difficulties
- ☐ Unseen Disability, e.g. Diabetes, Epilepsy, Asthma
- ☐ Multiple Disabilities
- ☐ A Disability not listed above
- ☐ Autistic Spectrum Disorder
- ☐ Registered Disabled Person
- ☐ Information refused

What religion, religious denomination, or body does your client belong to?

Tick relevant box

- ☐ None
- ☐ Church of England
- ☐ Roman Catholic
- ☐ Other Christian
- ☐ Muslim
- ☐ Buddhist

Tick relevant box

- ☐ Sikh
- ☐ Hindu
- ☐ Baha'i
- ☐ Parsi
- ☐ Jewish
- ☐ Rastafarian

Tick relevant box

- ☐ Pagan
- ☐ Other (please state)

  _____

- ☐ Information refused

Next of Kin	Emergency contact
Name: Address: Postcode: Relationship:	Name: Address: Postcode: Relationship:
Other Significant People **(include address & telephone contact details)**	**GP Contact Details**
List any other significant people who may have a responsibility for the welfare of the client, e.g. Guardian, Foster Carer, Health Professional etc.	Name: Address of Surgery: Postcode: Telephone: Fax: Email:

Client / Service User Permission and Agreement	Information Sharing **Improving the quality of care for service users**
Tick relevant box ☐ YES, the Client / Service User is aware of the referral / reason for contact ☐ NO, the Client / Service User is not aware of the referral / reason for contact ☐ YES, the client / service user has agreed to your service becoming the referral service and the sharing of information. ☐ NO, the client / service user has not agreed to your service becoming the referral service and the sharing of information.	Tick relevant box ☐ YES , the client / service user has been informed that information may be shared between our service and other services that may be of help to them ☐ NO, the client / service user has not been informed that information may be shared between our service and other services that may be of help to them ☐ YES, the client / service user has agreed to the sharing of information. ☐ NO, the client / service user has not agreed to the sharing of information.

Summary of Risk Evaluation / Medication / Issues

It is the duty of care and responsibility of the referring professional to highlight:

1. Any known risk of harm to self or others
2. Any known prescribed medication
3. Assessment / Evaluation of Issues

Risk Assessment

If no known risk of harm to self or others, write clearly "NOT APPLICABLE"

Medication

If none, write clearly "NOT APPLICABLE"

Issues

Write clearly, preferably using BLOCK CAPITALS

Any other comments

External Agency & Assessor Statement and Details

Statement

This referral form has been constructed by Crisis Point to provide an aftercare service for all clients / service users presently within their service, or wishing to use their service.

I declare, as the named person of the named agency below, that the information contained within this form is true, accurate and confidential.

Name of Assessor making referral:	
Signature:	
Name of Agency making referral:	
Address of Agency making referral:	
Position / Job title:	
Contact Telephone Number: Fax Number: Email Address:	
Date of first contact with Service User:	
Date of referral to Crisis Point:	

Data Protection

All information submitted or received will be protected by the Data Protection Act 1998 and subsequent amendments, this act forms an integral part of the Confidentiality Policy of Crisis Point.

Crisis Point Assessor Statement and Details

Statement

This referral form has been constructed by Crisis Point to provide an aftercare service for all clients / service users presently within our service, or wishing to use our service.

As the named person below using and signing this form, I declare that the information contained therein is true, accurate and confidential.

Name of Assessor:	
Signature:	
Position / Job title:	
Contact Telephone Number: Fax Number: Email Address:	
Date of first contact with Service User:	
Date of referral to External Agency:	
Name of External Agency:	
Name of External Agency's representative:	

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