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| **Details of person being referred:** |  | **How did you hear about CCC / Referrer details:** |
| **Surname:**  | **Name:**  |
| **First Name:**  | **Job Title:**  |
| **Date of Birth:**  | **Age:**  | **Organisation:**  |
| **Address (please include postcode):**  | **Contact No:**  |
|  | **Details of GP *(unless already given above)*** |
|  | **Named GP:** |
| ***Can we send post to this address?* Yes / No** | **Surgery Name:** |
| **Mobile No:** **Landline number (if no mobile):**  | **Please BRIEFLY give the MAIN reason for referral** **(e.g. domestic abuse)** |
|  |
| ***Can we phone you on above number/s?* Yes / No** |
| ***Can we send texts to above number?* Yes / No** |
| ***Can we leave voicemails on above number/s?* Yes / No** |

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| **Email Contact & Permissions:**  |
| **Email Address of person being referred:**  |
| **Can we contact you by email?**  | **Yes / No** | **Can we send updates about CCC by email?**  | **Yes / No** |
| **Can we send occasional surveys or opinion polls about CCC by email? Yes / No** |

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| **Health Information:** |
| **Please tell us about any illnesses or conditions including:*** **mental health problems**
* **physical disabilities**
* **asthma**
* **epilepsy**
* **hearing/visual impairments**
* **learning difficulties**
 |  |
| **Do you need any adjustments to access our services?**  |  |
| **Please list any prescribed medication** |  |
| **Who can we contact in an Emergency?** ***Please give:*** * *Their name;*
* *Their contact number*
* *Their relationship to you*
 |  |
| **Services Information:** |
| **Are you or have you been involved with any other services, e.g., Social Services, Home Treatment Team, Jobcentre, Carers Centre?** |  **Yes ❑ No ❑** |
| **Date of MARAC (if applicable)** |  | **Pending or current court case?** |  |
| **Can we share information about your engagement with CCC with other organisations you are**  **Yes ❑ No ❑****involved with, including your GP?** |
| **What would you like to gain from accessing CCC services? E.g., confidence, help for anxiety** |
| **Which CCC services would you like to access?** |
| **Availability for counselling / CBT:** **(days / times)** |  |
| **Preference for counselling / CBT:** **(F2F / Phone / Zoom):** |  |

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| **OPTIONAL SECTION:** **Are you happy to answer some Equalities information? This is only ever reported ANONYMOUSLY** |
| **Your Ethnicity** |  | **Your marital status** |  |
| **Are you Disabled?** |  | **Culture, Belief, Religion** |  |
| **Your sexual orientation** |  | **Gender Identity** |  |
| **Have you ever identified as transgender?** |

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| **Confirmation:** |
| **For assessments completed in person:** **By signing below I understand and agree that the information on this form is correct to the best of my knowledge.****Service User Signature: Date:** |
| **For assessments completed over the phone / online:** **Sign below to confirm that the client verbally stated the information on this form is correct to the best of their knowledge****Team Member Signature: Date:** |

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| **Referral Date:** |  | **Referral Route: (online / email / phone)** |  |
| **Assessment Type:** |  | **Assessment Date:** |  |