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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:** |  | |