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| **Section 1: This section is for chrysalis centre admin and not to be completed by the referrer.** |
| **Referral Date:** |  | **Referral Route:**  |
| **Registration Type:** |  | **Registration Date:**  |

**Sections 1 & 7 are to be completed by Chrysalis Centre admin**

**Referrer / client to complete sections 2 – 5 below. Section 6 is optional**

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| **Section 2: Client & Referrer Details** |
| **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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| **Section 3: Email Contact & Permissions** |
| **Email Address of person being referred:**  |
| **Can we contact you by email?**  | **Yes / No** | **Can we send updates about the Chrysalis Centre by email?**  | **Yes / No** |
| **Can we send occasional surveys or opinion polls about the Chrysalis Centre by email? Yes / No** |

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| **Section 4: Health Information: Do you have any of the following illnesses or conditions (Tick all that apply)** |
| **Mental Health Problems** | 🞏 | **Learning Difficulties** | 🞏 | **Epilepsy** | 🞏 |
| **Physical Health Problems** | 🞏 | **Asthma** | 🞏 | **Seizures** | 🞏 |
| **Hearing / Visual Impairments** | 🞏 | **Any other serious / life threatening conditions** | 🞏 |
| **If you have ticked any of the above, please provide any relevant information below including medication, adjustments:** |
| **Please provide below details of someone we can contact on your behalf in an emergency:** |
| **Full Name** | **Contact Number** | **Relationship to you** |
| **Section 5: Service Information** |
| **Are you involved with any other services, e.g., Social Services, Home Treatment Team, Jobcentre, Safe2Speak?** |
|  |
| **Can we share information with other professionals about your engagement with Chrysalis Centre?** | **Yes** | 🞏 | **No** | 🞏 |
| **Please indicate below if you have ever been referred to the MARAC (Multi-Agency Risk Assessment Conference)** |
| **Referred to MARAC** **in the last 6 months** | 🞏 | **Referred to MARAC** **more than 6 months ago** | 🞏 | **Date of MARAC** **if known** |  |
| **Please indicate below if you are involved in a pending or current court case and the reason why (e.g., child custody)** |
| **Pending** | 🞏 | **Current** | 🞏 | **Reason:**  |
| **Please indicate what you would like to gain by engaging with the Chrysalis Centre. Tick all that apply** |
| Reduction in anxiety | 🞏 | Support for addiction | 🞏 | Improve self-esteem | 🞏 |
| Stress Management  | 🞏 | Support with anger | 🞏 | Increased confidence | 🞏 |
| Support for depression | 🞏 | Support for trauma | 🞏 | Assertive Skills | 🞏 |
| Domestic abuse support | 🞏 | Reduce suicidal thoughts | 🞏 | Social inclusion | 🞏 |
| Bereavement support | 🞏 | Coping skills | 🞏 | Improved relationships | 🞏 |
| Work / volunteering or FE | 🞏 | Improved Wellbeing | 🞏 | Other (use box below) | 🞏 |
| **If you ticked other, please explain:**  |
| **Which services would you like to access at the Chrysalis Centre?** |
|  |
| **Counselling requires that you commit to attending for a one-hour session at the same time on the same day each week for a minimum of 8 weeks. Appointments are available in person, over the phone or by zoom. Please indicate your preference/s and your availability so that we can allocate you to a suitable counsellor. Tick all that apply** |
| **In person** | 🞏 | **Phone** | 🞏 | **Zoom** | 🞏 | **Availability:** |

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| **Section 6: OPTIONAL. Equalities information 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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| **Section 7: This section is for chrysalis centre admin and not to be completed by the referrer.** |
| **By signing below I understand and agree that the information on this form is correct to the best of my knowledge.****Team Member Signature: Date:** |