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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?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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:** |