

Client Reference:



60 Hartington Street
Barrow in Furness
Cumbria
LA14 5SR

Telephone Number: 01229 820828

Text Service: 07860025347

Email: enquiries@birchalltrust.org.uk

Website: www.birchalltrust.org.uk

SELF-REFERRAL FORM

The Birchall Trust accepts referrals from individuals upon full completion of this form. Before completing this form please carefully read the following information to see if now is the right time for you to engage in regular weekly counselling sessions with The Birchall Trust.

- The Birchall Trust's counselling hours are Monday – Friday 9am – 4pm. Therefore you will need to be able to commit to attending counselling regularly at the same time and day each week within our counselling hours.
- Counselling is a two-way process in that you need to be ready to fully and actively engage in order for it to be helpful.
- To be able to fully engage in counselling this has to be your decision. If someone else is telling you to attend counselling you may find the process difficult or you may not attend. Therefore, if this is not your choice please contact us at a later date when you feel you want to come for counselling.
- Counselling can generate strong feelings and memories ask yourself whether you feel you can cope with these at this present time.
- Do you need to engage with another specialist service to help you with any coping mechanisms i.e. drugs, alcohol, self-harm before engaging in trauma informed counselling for issues around rape and/or sexual abuse.
- Unfortunately due to the high demand for our service we are unable to predict when your first counselling session will be therefore you may wish to contact your GP or another service for support whilst you are waiting.
- Please also note that we cannot offer a service whilst you are seeing another counsellor or psychological therapist, or if you are currently receiving a high level of mental health care.

This referral form **MUST** only be completed by the person who requires counselling if this form is completed by anybody else the referral will not be accepted.

Incomplete forms will not be accepted and returned or you may be contacted again if further details are required.

As a confidential and professional service we adhere to strict data protection practices in line with current legislation within our current data protection and privacy policy.

Please note: The Birchall Trust agree to support all survivors of sexual violence unless they are under investigation or have been convicted of any sexual offences.

First Name(s):

Surname:

Date of Birth: Age:

Address:

Post Code:

Please let us know if it is ok to write to the above address Yes No (please tick)

Residential Situation (e.g. living alone, partner, parents)

Telephone Number Ok to leave messages Yes No

Mobile Number Ok to leave messages Yes No

Email Address Ok to email Yes No

I wish to attend counselling in any of the following areas (please tick/ highlight relevant area(s))

Barrow Kendal Morecambe *Lancaster

*Please note the majority of our counselling in North Lancashire takes place in Morecambe. There are limited spaces in Lancaster available though you may incur a longer waiting period.

I would like to see a Female Counsellor Male Counsellor Either

How did you hear about The Birchall Trust (please tick/highlight as appropriate)

NHS Family/Friend Police Returning Client

Voluntary Sector SARC Birchall Publicity School/University

Childrens Services Other please specify other

Please tick/highlight relevant option

I have experienced rape and/or sexual abuse within the last 12 months

I have experienced rape and/or sexual abuse over 12 months ago

My friend/family has experienced rape and/or sexual abuse

I have experienced childhood sexual abuse (under 16 at the time)

Is coming to The Birchall Trust your own decision? Yes No

Please tick/highlight inside the table below to indicate which days and times are best for you to attend counselling
Please note we our counselling service is open 9 - 4

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any physical difficulties or disabilities we may know about? e.g. hearing problems, visual impairment, mobility problems. If yes, please provide details below.

Are you currently engaging with a medical professional e.g. counsellor, psychologist or psychiatrist? If yes, please give full details below.

Would you be happy and give consent for The Birchall Trust to contact the medical professional you are currently involved with to gain further information?

Yes No

Have you engaged in counselling, with a psychologist or psychiatrist in the past? If yes, please provide details below.

Please explain why you want to come for counselling at this moment in time:

Please give details as to how you are currently being affected:

Please give any further details that you feel would help us to understand your current circumstances:

Please provide us with your GP contact details

GP Surgery

GP Name

Telephone Number

Please provide us with your Mental Health workers contact details if you have one

Mental Health Worker's Name

Address

Telephone Number

Diversity Indicators

To ensure that we continue to fully meet the needs of such a diverse client group, it is important that we are able to monitor all forms of diversity. Please let us know if you have any individual diversity requirements.

Gender Male Female Transgender Ethnicity

Religion Sexuality

Marital Status

Parental Status

Not a Parent Yes, not live with Yes, some live with Yes, all live with

Please complete the following questionnaires this will help us to understand you're currently feeling

Please circle or highlight your answer

OVER THE LAST 2 WEEKS. HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING PROBLEMS:	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or family down	0	1	2	3
Trouble concentrating on things such as reading the newspaper or watching TV	0	1	2	3
Have other people noticed that you have been moving or speaking slowly? Or you have been fidgety, restless or moving more than usual?	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

PHQ-9 Total score

OVER THE LAST 2 WEEKS. HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING PROBLEMS:	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on the edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it's hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

GAD-7 Total score

How much you have been bothered by that problem <u>in the past month.</u>	Not at all	A little bit	Moderately	Quite a bit	Extremely
Repeated, disturbing <i>memories, thoughts</i> or <i>images</i> of a stressful experience from the past?	1	2	3	4	5
Repeated, disturbing <i>dreams</i> of a stressful experience from the past?	1	2	3	4	5
Suddenly <i>acting</i> or <i>feeling</i> as if a stressful experience <i>were happening</i> again (as if you were reliving it)?	1	2	3	4	5
Feeling <i>very upset</i> when <i>something</i> reminded you of a stressful experience from the past?	1	2	3	4	5
Having <i>physical reactions</i> (e.g. heart pounding, trouble breathing, sweating) when <i>something</i> reminded you of a stressful experience from the past?	1	2	3	4	5
Avoiding <i>thinking about</i> or <i>talking about</i> a stressful experience from the past or avoiding <i>having feelings</i> related to it?	1	2	3	4	5
Avoiding <i>activities</i> or <i>situations</i> because <i>they</i> reminded you of a stressful experience from the past?	1	2	3	4	5
Trouble <i>remembering important parts</i> of a stressful experience from the past?	1	2	3	4	5
<i>Loss of interest</i> in activities that you used to enjoy?	1	2	3	4	5
Feeling <i>distant</i> or <i>cut off</i> from other people?	1	2	3	4	5
Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?	1	2	3	4	5
Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?	1	2	3	4	5
Trouble <i>falling</i> or <i>staying asleep</i> ?	1	2	3	4	5
Feeling <i>irritable</i> or having angry outbursts?	1	2	3	4	5
Having <i>difficulty concentrating</i> ?	1	2	3	4	5
Being " <i>super-alert</i> " or watchful or on guard?	1	2	3	4	5
Feeling <i>jumpy</i> or easily startled?	1	2	3	4	5

Total Score

Please use this space to provide any other details or comments regarding your referral

Have you ever been convicted of a sexual or violent crime, spent or un-spent? Yes No

Thank you for completing your referral form. Please check that you have completed the form as fully and as accurately as possible, and sign and date below.

Signed: Date:

Please return all completed forms to enquiries@birchalltrust.org.uk or post to The Birchall Trust, 60 Hartington Street, Barrow in Furness, Cumbria LA 14 5SR

Important information

Upon receipt of your referral we will email or text you within 3 working days to confirm that we have received your form. Your referral will then be checked by management and if any further information is required we will contact you to discuss your referral further. You will then be placed on to our waiting list. You will however be contacted approximately 6-8 weeks before commencing with your counselling to attend a pre-counselling assessment.

Please note that unfortunately due to the high demand for our service we are unable to indicate when you will commence with your counselling.

We will contact you on a regular basis to advise that you are still on our waiting list.

If at any time you decide you do not wish to attend counselling anymore could you please advise the office and we will remove you from the waiting list immediately.

The Birchall Trust Staff

This section is for office use only

Date received in office:	<input type="text"/>	Staff member who received referral:	<input type="text"/>
Date entered on CRMS:	<input type="text"/>	Staff member who entered on CRMS:	<input type="text"/>
Email/text sent to client date:	<input type="text"/>	Staff member who sent email/text:	<input type="text"/>
Date authorised:	<input type="text"/>	Management authorising:	<input type="text"/>

Questionnaire Scores

PHQ Total	<input type="text"/>						
GAD Total	<input type="text"/>						
PCL-C Total	<input type="text"/>	1-5	<input type="text"/>	6-12	<input type="text"/>	13-17	<input type="text"/>

Any other comments or actions from the office or management