The Birchall Trust

Counselling survivors of rape and sexual abuse in
South Cumbria and North Lancashire
Charity no. 1109637 Company no. 5424196

| Office use only | |
|---|---|
| Date referral received: | Client Ref no: |

# Under 18's referral form for counselling

**The criteria for accessing counselling with The Birchall Trust is survivors, family and friends who have been affected by rape and/or sexual abuse.**

- The Birchall Trust does not knowingly work with perpetrators of Rape and/or Sexual Abuse.
- Ensure you complete all the information, failure to do so will delay this referral.
- Please do not assume that all the referrals received will be able to be accepted by The Birchall Trust.
- We will firstly assess the client's stability from the information you provide and during a Pre-Counselling Appointment between The Birchall Trust and the referred client.
- If the referral is not able to be accepted by The Birchall Trust at this time you will be informed.
- If the client fails to engage with The Birchall Trust, the referral will be closed and you will be informed by email.
- If the client fails to attend 2 consecutive appointments their referral will need to closed due to the high demand for our service.
- All information given will be treated with the strictest confidence.
- Please complete and forward this form to The Birchall Trust: enquiries@birchalltrust.org.uk or 60 Hartington Street, Barrow-In-Furness, Cumbria, LA14 5SR

| Is the client aware of this referral: | Y | N |
|---|---|---|

| Area of referral Please specify | Barrow | Kendal | Morecambe |
|---|---|---|---|

| Please specify nature of the referral: | Childhood sexual abuse (under age of 16) | Recent Rape (Within the last 12 month) | Historic Rape |
|---|---|---|---|

| **Client's personal details** | | | | | |
|---|---|---|---|---|---|
| Full Name: | | | | | |
| Date of birth: | | Age: | | | |
| Address | | | | Is it ok to write to this address? | |
| | | | | Y | N |
| Postcode: | | | | | |
| Name of parent/guardian (if under 16 years old: | | | | | |

| **Client's phone details** | | Ok to leave messages | |
|---|---|---|---|
| Home number: | | Y | N |
| Mobile number: | | Y | N |
| Other: | | Y | N |

| Client's or parent's/guardian's email details | | Ok to email | |
|---|---|---|---|
| Email: | | Y | N |

| Please complete all the sections below regarding the client referred |
|---|
| Mental health issues: |
| Physical health issues: |
| Suicide actions and/or thoughts (Past and Present): |
| Self-harm (Past and Present): |
| Addictions (Past and Present): |
| Current medication: |
| Has there been an early needs assessment undertaken YES NO<br>If Yes please provide full details |
| Is this child currently open to Children Services YES NO<br>If yes please provide full details |
| Has this been reported to the police YES NO<br>Please provide full details. |
| Please give brief details about the situation for which counselling is being requested: |

| Children services details | |
|---|---|
| Name: | |
| Address<br>(inc postcode): | |
| Telephone number: | |

| GP's details | |
|---|---|
| Name: | |
| Surgery Name & Address (inc postcode): | |
| Telephone number: | |

| Referrers details | |
|---|---|
| Name: | |
| Job title and agency if appropriate: | |
| Address (inc postcode): | |
| Office number: | |
| Mobile number: | |
| Email: | |