 Contact Information

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Name |  | D.O.B |  |
| Address |  | Postcode |  |
| Email |  | Okay to use?Yes No | Note: |
| Phone |  | Okay to use?Yes No | Note: |
| Emergency Contact |  | Contact Number |  |
| Link Teacher or Counsellor |  | Contact Number |  |
| Gender | Rather not say | Female | Male | Transgender | Intersex |
| Ethnicity | Rather not say | Self-defined as... | Disability: | Yes | No |

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| --- | --- | --- | --- | --- | --- | --- |
|  | Mental health |  | Self harm |  | Personal safety |  |
| Emotional distress |  | World events |  | Practical support |  |
|  | Future work options |  | Study / Exam stress |  | Physical health |  |
| Work stress |  | Finance / Debt |  | Drugs \ Alcohol |  |
|  | Relationships |  | Loneliness |  | Bereavement |  |
| Bullying |  | Social media |  | Self-esteem |  |
|  | Hopelessness |  | Suicidal Thoughts |  | Body Image |  |
| Rights / Advocacy |  | Criminal Justice |  | Safeguarding concerns |  |
| Other: Please tell us |

Summary (please tick all that apply)

Please tell us how you think we can help

Reason for Referral

Signed……………………………………………………..Date……./………./………

Please return to southayrshiresh@penumbra.org.uk

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|  |  |
| --- | --- |
| **Name \ Organisation** | **Contact** |
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A copy of this form will be kept. The law states that your personal information must be held in confidence unless under exceptional circumstances such as protecting someone from harm. We will securely store a copy of this form and retain it according to our data protection policies - copy of which will be available to you on request. To help ensure that you receive the support best suited to your needs, this information may be shared with other agencies and persons, but only with your agreed consent.

Data Protection

|  |  |  |
| --- | --- | --- |
| **When would you say the self-harm started?** | Can you let us know how long ago and if there was a particular event or trigger beforehand? |  |
| **How often would you say the self-harm occurs?** | e.g. Average number of times per week/month/day? |  |
| **What form does the self-harm most often take?** | Can you let us know how you, (or the person you are referring) is self-harming? |  |

|  |  |
| --- | --- |
| Please tell us if there are any safety concerns for the person or our team. |  |

Additional Information

If you, or the person you are referring, already has self-harmed, please let us know how often you think this is happening. Please feel free to leave any of the questions below blank.

