Self-Referral Form

She Is Supported (SIS) Project

Please call us on **020 7267 1321**

Thank you for your interest in referring for Counselling & Psychotherapy with the **Brandon Centre**, as part of the **She Is Support (SIS) Project.**

Please complete this form, giving as much information as you can, and email the form to **counselling@brandoncentre.org.uk**

Once we have received your form, we will let you know whether or not you have been accepted onto our waiting list. It is possible that someone at Brandon Centre may call you asking for more information about your referral. This is so that we have the necessary information to make sure that you're provided with the right kind of support. Please fill the form out to the best of your knowledge as the more detailed the referral as well as pre-counselling conversation, the better.

Please ensure you update us if your contact details change as we will send emails, texts and (in some cases) letters confirming your assessment time and date.

We are only able to offer appointments to girls aged 10-24, attending one of the following Islington youth centres:

Please tick the appropriate box below.

Mary's ☐ Prospex ☐ Highbury Roundhouse ☐

Need help immediately?

Please note that we are not an emergency service. If you need urgent support please contact your GP, or go to the nearest hospital A&E.

If you are under 18, you can call **Childline any time 24/7 on 0800 1111**; or can call the **NCL Under 18s mental health crisis line on 0800 151 0023**.

If you are over 18, you can call the **24-hour Crisis Line on 020 3317 6333.**

Young Person's Details			
Referral Date:			
First Name		Surname	
Date of Birth		Age	
Gender		Ethnicity	*Categories on final page*
Telephone number		Sexuality	*Categories on final page*
Email address			
Borough			
Home Address			
Postcode			
Consent to send letters?	Yes ☐	No ☐	
Preferred contact method			
Are you currently in education, employment, or training	Yes ☐	No ☐	
If yes, where?			

Other Services			
What is the name of your GP practice?			
Do you see a regular GP, if so what is their name?			
Are you happy for us to contact your GP to let them know about your referral?	Yes ☐		No ☐
Have you received counselling or mental health support from other services: (eg. CAMHS; iCope; the crisis team etc)	Yes ☐	Name of service:	No ☐
If yes, please give us some information about the help you received			
If yes, do you give us consent to contact any of these services?	Yes ☐		No ☐

Have you or your family ever had support from Social Services?	Yes ☐	Name of service:	No ☐
If yes, do you give us consent to speak to Social Services?	Yes ☐		No ☐

Clinical Information

Please could you state why you would like counselling now.

How long have you had these problems?

How do these problems impact your day to day (e.g. sleep, eating, work)?

Can you tell us about your living situation (Where are you living? Who is at home? Is your living situation a problem at the moment?)?

If you have been in counselling before, how did you find this experience?

Clinical Information

Many people who are feeling distressed, down or stress have thoughts or urges to hurt themselves.

Are you currently experiencing thoughts of ending your life? Yes ☐ No ☐

If yes, do you feel like you can keep yourself safe? Yes ☐ No ☐

If you do not feel able to keep yourself safe and need urgent support please contact your GP, or go to the nearest hospital A&E. If you are under 18, you can call Childline any time 24/7 on **0800 1111**; or if you are over 18 you can call the 24-hour Crisis Line on **020 3317 6333**.

If you've experienced thoughts of suicide in the past, or attempted to take your own life, please provide details below, including services you've accessed:

Have you ever experienced thoughts of self-harm? Yes, currently ☐ Yes, in the past ☐ No, never ☐

Have you ever acted on thoughts of self-harm? Yes, currently ☐ Yes, in the past ☐ No, never ☐

If you have deliberately harmed yourself in the past, please provide details below, including services you've accessed:

Is there a concern about drug or alcohol use? Yes ☐ No ☐

If yes, please tell us a bit more about this concern:

Is there anything else you think is important for us to know about in relation to your care? (E.g. disabilities or problems in travelling to certain areas)

Your ethnic group (*Please choose one of the following*):		
Any other ethnic group ☐ Please state: Prefer not to say ☐ Unknown ☐	**White** White British ☐ White Irish ☐ Any other White background ☐	**Mixed** White & Black Caribbean ☐ White & Black African ☐ White & Asian ☐ Any other mixed background ☐
Asian/Asian British Indian ☐ Pakistani ☐ Bangladeshi ☐ Any other Asian background ☐	**Black/Black British** Black Caribbean ☐ Black African ☐ Black British ☐ Any other Black background ☐	**Chinese or other** Chinese ☐ Middle Eastern ☐

Your sexuality (*Please choose one of the following*):
Heterosexual/Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Other: Prefer not to say ☐