

**NIDAS Art Therapy Services Referral Form**

**Eligibility criteria:**

Our Art Therapy service is available for anyone in the Mansfield or Ashfield areas wanting to access therapeutic support either individually or in a group setting. The service is available to anyone over the age of 5 who have previously or are currently experiencing Domestic Abuse.

**Before you begin:**

Check – is your client is aware of their referral to our service? [ ]

Does your client consent for us to make safe contact with them? [ ]

**Completing this referral form:**

By completing this referral form, you’re helping us to make contact with the client as safely and quickly as possible. We would appreciate it if you could include as much information as possible - this saves the client from being asked the same questions twice and helps us to understand more about their particular needs and circumstances.

**Completed referral forms should be sent to:**

NIDAS – Nottinghamshire Independent Domestic Abuse Services

Address: NIDAS, Mansfield Business Centre, Ashfield Avenue, Mansfield, NG18 2AE

Phone: 01623 683250

Email: referrals@nidas.org.uk

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| --- |
| **How did you hear about our service?** |
| Search Engine [ ]  Email [ ] Social Media [ ] Education [ ] Health [ ] Housing [ ] Word of mouth [ ]  | Police [ ] Social Care [ ] Citizens Advice [ ] Solicitors [ ] Mental Health Services [ ] Family Service [ ] Other [ ] Please specify:  |

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| 1. **Referrer Details**
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| Date of referral: |  |
| Referrer’s name |  |
| Organisation name |  |
| Role/ job title |  |
| Contact number  |  |
| Contact email |  |

1. **Client contact information**

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| **Names**  |
| First name |  |
| Last name |  |
| Other names/preferred names |  |
| DOB |  |
| **Contact info for this referral** \**CYP only* |
| Please contact: | CYP directly [ ] Parent/ Carer [ ]  |
| Parent/ carer name: |  |
| DOB: |  |
| Address |  |
| Safe contact notes: |  |
| Can we send post to this address? |  Post to this address[ ]  |
|  **Details Safe to contact?** |
| Phone |  |
| Email  |  |
| Safe contact notes  |  |
| Preferred contact time: |  |
| Safe to contact methods: | Call [ ] Text [ ] Email [ ] Leave voicemail messages [ ]  |
| **Next of kin – who can we contact in an emergency?**  |
| Name  |  | Relationship |  |
| Contact details  |  |
| Safe contact notes |  |
| **School/College/Nursery info:** *\*CYP only* |
|  |
| Are the child/young person in receipt of free school meals? | Yes [ ] No [ ] Don’t know [ ]  |
| **Safeguarding** *\*CYP only* |
| Are social care involved in this case? *(Please give details)* | Yes [ ] No [ ] Don’t know [ ]  |
| Nature of involvement: *(please give details, current or previous involvement)* |  |
| Name of social worker and contact details: *(if relevant)* |  |
| **Are there any other services/agencies involved with this family?** |
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| **Accessibility requirements**  |
| Does this client have any accessibility requirements (for example, hearing loop, braille documents) | Yes [ ]  No[ ]  Don’t Know [ ]  | *If yes, please provide details:* |
| Do they have any allergies? | Yes [ ]  No[ ]  Don’t Know [ ]  | *If yes, please provide details:* |
| Does this client require an interpreter? | Yes [ ]  No[ ]  Don’t Know [ ]  | *If yes, please provide details:* |

1. **Client equalities monitoring**

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| --- | --- |
| How would this client describe their gender? | Female [ ] Male [ ] Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Don’t Know [ ]  |
| Is their current gender different to the sex they were assigned at birth? | Yes [ ] No [ ]  Don’t know [ ]  |
| Do they consider themselves to have any kind of disability? (please tick any that apply) |  Physical [ ]  Learning [ ] Mental Health [ ] Deaf/ hearing impaired [ ] Blind/ visually impaired [ ] Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Don’t Know [ ]  |
| How would they describe their ethnicity? |
| White British [ ]  White Irish [ ] White Gypsy or Irish Traveller [ ] Any other White background [ ] Asian British [ ] Asian Indian [ ] Asian Pakistani [ ] Asian Bangladeshi [ ] Any other Asian background [ ] Chinese [ ]  Arab [ ]  | White and Black Caribbean [ ] White and Black African [ ] White and Asian [ ] Any other mixed/ multiple background [ ] Black British [ ] Black African [ ] Black Caribbean [ ] Any other Black background [ ] Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Don’t Know [ ]  |
| Do they have a faith/ religion?  |
| No religion [ ] Bahai [ ]  Buddhist [ ] Christian [ ] Hindu [ ] Jewish [ ] Jain [ ]  | Muslim [ ]  Shinto [ ]  Sikh [ ] Zoroastrian [ ]  Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Don’t Know [ ]  |
| What is their sexual orientation? | Heterosexual/ straight [ ] Gay woman/ Lesbian [ ] Gay man [ ] Bisexual [ ] Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Don’t Know [ ]  |
| Is the young person in a relationship? *(Relevant for teen outreach service 11+)* | Yes [ ] No [ ] Don’t know [ ] N/A [ ]  |
| Is the young person pregnant?*(Relevant for teen outreach service 11+)* | Yes [ ] No [ ] Don’t know [ ] N/A [ ]  |
| *If yes, please give additional details* *e.g., expected due date, is the alleged perpetrator father to the unborn baby?* |  |

1. **Client support needs/ vulnerabilities**

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| ***Please tell us more about any support needs the client may have:*** |
| Mental Health [ ] Physical Health [ ] Sexual Health [ ]  Substance misuse [ ] Aggressive behaviour [ ]  Self-harming/ suicidal feelings [ ]  Issues with work or educational attainment/ attendance [ ]   | Stress [ ]  Bereavement [ ]  Confidence/self-expression [ ]  Social isolation [ ] Bullying/ being bullied [ ]  Experiencing abuse [ ] Other *(please specify below)*  |
| **Additional details:** |
|   |

1. **Alleged perpetrator/s**

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| **Information about the alleged perpetrator, if known:** |
| Name |  |
| Relationship to child/ young person |  |
| Address |  |
| DOB |  |
| Additional details regarding alleged perpetrator e.g. risk |  |
| *If there is more than one alleged perpetrator, please provide additional details in the box below:* |
|  |

1. **History of support**

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| --- | --- | --- |
| Currently or previously receiving Therapy – including Counselling, Talking, Art, etc. | Yes [ ]  No[ ]  Don’t Know [ ]  | *If yes, please provide details:* |
| Other services/ professionals currently or previously involved: | *Contact details:* |

1. **Reason for referral**

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| **Why are you making this referral – how could this client benefit from our support?** |
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| **Are there any known risks to working with this client?**  |
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Thanks for taking the time to complete this referral. If you have any queries, please contact us on 01623 683250 or hello@nidas.org.uk.