Graphical user interface, application

Description automatically generated

**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](mailto:referrals@nidas.org.uk)

|  |  |
| --- | --- |
| **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: |

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

1. **Client contact information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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?** | | | | | |
|  | | | | | |
| **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**

|  |  |
| --- | --- |
| 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**

|  |  |
| --- | --- |
| ***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**

|  |  |
| --- | --- |
| **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**

|  |  |  |
| --- | --- | --- |
| 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**

|  |
| --- |
| **Why are you making this referral – how could this client benefit from our support?** |
|  |
| **Are there any known risks to working with this client?** |
|  |

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](mailto:hello@nidas.org.uk).