For CLEAR Office Use		Receipt sent:	
Date referral received:		Signposting sent:	
Funding pathway:		On waiting list:	
Client Code:		Printed & Filed:	

CLEAR ADULT Referral Form

SECTION 1: Your details (please enter the details of the person requiring support). **indicates required information*

We have asked for this information so we can carefully consider the best support for you. ***Please see end of this form for our privacy notice.***

Personal Details		
Name:*	**Telephone Number:***	
Gender: *	**Date of Birth:***	**Age: ***
Your Address:*	**Email Address: ***	
GP Name & Surgery Details:*		
Employment status: Working ☐ Absent due to sickness ☐ Not working ☐ Looking for work ☐		
Primary Language * English ☐ Other (please specify) ☐		

SECTION 2a: Referral Details. This will help us to identify how we can best support you

*Please tell us why you are seeking our support (this can be brief or detailed, please only share what you feel comfortable with sharing)**
Have you reported what happened to you to the police? Yes ☐ No ☐ **If yes please provide further details:**

Please answer the questions below:*		
Are you experiencing current suicidal thoughts?	Yes ☐	No ☐
Are you feeling at immediate risk to yourself?	Yes ☐	No ☐

If you answered 'Yes' more support is available for you below:

We would advise that you contact your GP for further support even if you are referring to CLEAR.

Go to this link: *https://www.cornwallft.nhs.uk/i-need-help-now/ or call the mental health helpline on 0800 038 5300*

If you are a professional making this referral please consider further crisis support for the person you are referring to CLEAR. This referral is not a handover of care, we would prefer to work collaboratively with you to support people who are referred to CLEAR. If there are additional needs for the client, additional support needs to be in place for us to accept this referral.

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Section 2a: Referral Details.

Please can you briefly let us know what has led you to reach out to CLEAR for support now?
How did you hear about CLEAR?
Website ☐ Google ☐ GP ☐ Friend ☐ Professional Recommendation (Please specify) ☐ Other (Please specify) ☐
Are you waiting for a court case?
Yes ☐ No ☐ If yes please provide further details:

SECTION 2c: Your Circumstances

*To help us provide the best support for you please could you tick any boxes below that you relate to:**			
Anxiety		Depression	
PTSD (including Complex PTSD)		Eating Disorder(s)	
Dissociation		Autism or Asperger's	
Personality Disorder (please specify which one if you are able to)		Learning Disability(s)	
Bipolar		Self-Harm	
Psychosis		Recent Suicide Attempt	
Drug & Alcohol difficulties		Feeling like you want to harm other people	
Rape or sexual assault		Feeling at risk from other people	
Childhood Sexual abuse		Refugee or seeking asylum	
Anger Difficulties		Experience of war, torture, or trafficking	
Experience of Domestic Abuse		Time in prison	
Serious Physical Health Difficulties		Being a victim of a crime	
If something you are struggling with has not been listed above, please use the box below to write more details (if you feel able to):			

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Section 2d: Further Information

Are you taking any medication related to mental health difficulties? *(It can be helpful for us to be aware of any medication you are taking as this can impact therapy in various ways)*

Please could you advise us if you have any physical health difficulties *(It is helpful for us to be aware of additional health needs so we can support you in the best way):*
Do you class yourself as clinically extremely vulnerable in terms of COVID-19?* Yes ☐ No ☐

Please tick if you relate to any of the below:			
Are you pregnant or have you recently given birth?	Yes ☐	No ☐	
Are you a parent or carer?	Parent ☐	Number of children: Ages:	Carer ☐
A veteran (or currently serving in the forces)?	Yes ☐	No ☐	

SECTION 2e: Previous Therapy

Have you previously had counselling/psychotherapy?
Yes ☐ No ☐ If yes please provide further details (how many sessions, which service)
*I have had counselling with CLEAR/CRASAC before? ** Yes ☐ No ☐
Please be aware that if you have previously had counselling with CLEAR/CRASAC then we may be limited in what further support we can offer you. We can discuss this with you on an individual basis.
Do you have a preference for face to face, online or telephone counselling?
Face to face counselling ☐ *Online counselling* ☐ *Telephone counselling* ☐

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We often have trainee counsellors who are fully supported by CLEAR to offer counselling to you, please tick below if you would be comfortable working with a trainee counsellor?
Yes, I am ok to work with a trainee counsellor ☐ No, I would not like to work with a trainee counsellor ☐

SECTION 2f: Current Support from other agencies

Please put a tick next to any service that is supporting you at the moment:			
Adult Community Mental Health Service (CMHT)		SOLO	
Police (please provide a crime number if you have one)		Social Care	
Refuge		Probation Service	
First Light		Housing	
Susie project		Waves	
IDVA/ISVA		Positive People Project	
Pentreath		Who Dares Works	
Any other Service(s):			

If you can, please write the details of people who are supporting you below:	
Name: Contact number: Service:	Name: Contact number: Service:

Convictions*
Have you ever been convicted of harming another? (for example, domestic abuse, sexual assault, stalking, harassment) Yes ☐ No ☐ If yes please provide further information:
Please note we are not able to support those convicted of harming another.

SECTION 3: Referrer's Details

If this is a self-referral please leave blank but ensure your contact details are entered in section 1.

Referring Persons Name		*Service/Agency*	
Role		*Telephone*	
Address		*Email*	
Signature		Date	

PRIVACY NOTICE

CLEAR respects the personal and sensitive information you have provided is confidential. This means we store it securely and control who has access to it. We will not share any information without your consent or where we are not legally required to do so. We will only share such information as necessary, and where we are satisfied that the other organisation is entitled to receive it and will keep your information secure. Please refer to the Privacy Policy on our website, at www.clearsupport.net for further information.

By signing this form you give consent to this referral. Please inform us of this in writing if you wish to withdraw your consent.

YOUR SIGNATURE (Self Referrals)

Client's Signature:*		Date	

If completing this form electronically please indicate your consent to our privacy notice by typing your name as an electronic signature. Thank you.

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Monitoring Information (We collect this information as it is in relation to our funding)

Ethnicity	
White British	
White Other	
Cornish	
Mixed	
Asian or Asian British	
Black or Black British	
Chinese	
Other	
Declined to Answer	

Age at referral	
1-15	
16-24	
25-34	
35-44	
45-54	
55-64	
65-74	
75+	
Declined to Answer	

Gender Identity	
Male	
Female	
Intersex	
Transgender	
Transexual	
Declined to Answer	

Other characteristics	
Pregnant	
Maternity-baby under 6 months old	
Caring responsibilities- (other children)	
Other caring responsibilities- (adult)	
Married	
Same sex civil partnership	
Living with partner	
Live alone	
Live with others (friends/family/lodger)	

Sexual orientation	
Heterosexual/Straight	
Lesbian	
Homosexual	
Bisexual	
Declined to Answer	

Definition of a Disability
A physical or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out day to day activities.

Do you consider yourself to have a Disability?	
Yes	
No	
Mental	
Physical	

If you identify as having a disability can you please state briefly what it is:

Have you experienced **FGM** (female Genital Mutilation)? In main form *(This may include being intentionally injured or cut during a traumatic experience)*	
Yes	
No	