** Off Centre at Family Action **

**Self Referral Form**

Off Centre is not a crisis service

If you are worried about your mental health and feel that you are unable to keep yourself safe please call City and Hackney Mental Health Crisis line on 0800 073 0006 or the Samaritans on 116 123.

In an emergency please call 999 or attend your nearest A&E department.

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| SELF - REFERRAL FORM: \*Young people must be 16-25yrs old and be registered with a City & Hackney GP to access Off Centre\* | | | | | | | | | | | | | | | |
| **Name:** | |  | | | | **Surname:** | | |  | | | | | | |
| **GP surgery:** | |  | | | | **Age:** |  | | **Date of Birth:** | |  | | | | |
| **NHS number (if known):** | |  | | | | |
| **Gender:** MaleFemale  Non-Binary  Other  Please state: | | | | | | **Do you identify as trans?**  Yes  No  Not sure  Prefer not to say | | | | | | | | | |
| **Pronouns:** | |  | | | | **Religion / Belief:** | | |  | | | | | | |
| **Ethnicity:** | |  | | | | **Nationality:** | | |  | | | | | | |
| **Sexuality:** | | Heterosexual (straight)Bisexual  Gay or Lesbian  Not sure  Prefer not to say  Other  Please state: | | | | | | | | | | | | | |
| **Address:** | |  | | | | | | | | | | **Postcode:** | | |  |
| **Living situation:** e.g. in hostel, with family, homeless | |  | | | | | | | | | | | | | |
| **Contact number:** | |  | | | | **Email address:** | | |  | | | | | | |
| **Is it okay to receive texts / voicemails / emails?**  Yes  No  if no, please give further details: | | | | | | | | | | | | | | | |
| **School / College / Occupation:** | | | In education  In employment  Not in education or employment  Name of education establishment: | | | | | | | | | | | | |
| **Name of person(s) with parental responsibility: (\*If YP under 18):** | | | | | | | | |  | | | | | | |
| **Main Carer(s):** Mother  Father  Grandparent  Step Parent  Guardian/Other  Foster Parent  Resident Key Worker | | | | | | | | | | | | | | | |
| **Do you have any children?** YesNoIf yes, please give name of child(ren) and date(s) of birth: | | | | | | | | | | | | | | | |
| Are you pregnant? | | | | YesNo Please state: | | | | | | | | | | | |
| Do you have learning disability? | | | | YesNo Please state: | | | | | | | | | | | |
| Do you consider yourself to have any developmental, medical or physical conditions? | | | | YesNo Please state:  If yes do you have any access needs? | | | | | | | | | | | |
| AREAS OF SUPPORT (PLEASE TICK AS MANY THAT APPLY) | | | | | | | | | | | | | | | |
| Low mood  Anxiety  Identity  Relationships  Trauma  Substance or alcohol misuse/dependency  Eating Issues  Abuse  Other, please state: | | | | | | | | | | | | | | | |
| **SUPPORT REQUESTED:** | | | | | | | | | | | | | | | |
| Talking Therapy  Creative arts Therapy  Advice & Information/Keyworking  Project Indigo (LGBTIQ+)  Unsure and would like to hear more | | | | | | | | | | | | | | | |
| **OVERVIEW OF SUPPORT** | | | | | | | | | | | | | | | |
| Why would you like to seek therapy? Please provide as much information as you can. | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **OTHER SERVICES THAT MAY SUPPORT YOU** | | | | | | | | | | | | | | | |
| Are you currently receiving / have you received support from any of the following services? | | | | | **Currently:**  Social Care  CAMHS  Adult Mental Health/Secondary Care Service  Neighbourhoods team  Specialist Psychotherapy Service  IAPT / Talk Changes  Young Hackney  Private Therapy  None  Other  (if other please detail)………………… | | | | | **In the past:**  Social Care  CAMHS  Adult Mental Health/Secondary Care Service  Neighbourhoods team  Specialist Psychotherapy Service  IAPT / Talk Changes  Young Hackney  Private Therapy  None  Other  (if other please detail)………………… | | | | | |
| If you are involved with other services for your emotional or mental health wellbeing please provide their contact details here: | | | | |  | | | | | | | | | | |
| Are you ok with Off-Centre contacting services you are involved in? | | | | | Yes  No  Not yet | | | | | | | | | | |
| Are you or have you been in care or had involvement with social services in the past? | | | | | YesNo Please state (include name of social worker): | | | | | | | | | | |
| How did you hear about Off Centre? | | | | |  | | | | | | | | | | |
| **CONSENT** | | | | | | | | | | | | | | | |
| **If you are the young person:**  I consent to Family Action:   * Processing and storing my information given on the form in accordance with The Data Protection Act 2018 and   General Data Protection Regulation 2016/679 (GDPR).   * Processing and storing the personal data I have provided and any supporting information that is required.   If my referral is accepted, Family Action can:   * Seek information from other relevant professionals such as health, social care, education, housing, local authority, police, legal and voluntary services professionals. * Share information with other relevant professionals such as health, social care, education, housing, local authority, police, legal and voluntary services professionals in order to support my needs.   \*Please note that if you do not consent, we will continue to offer you our support, but the services provided to you may be affected. You can discuss this with your allocated Off Centre staff member, and if you have any further queries, with a member of Off Centre Management Team on the details below. | | | | | | | | | | | | | | | |
| Name (YP): |  | | | | | Signed (YP): | |  | | | | | Date: |  | |

Please hand this form into reception at Off Centre or email to [**OffCentre@family-action.org.uk**](mailto:OffCentre@family-action.org.uk)

Off Centre at Family Action – Unit 7: The Textile Building, 29a-31a Chatham Place, London E9 6FJ

(entrance on Belsham Street)