



Please return as “Private and Confidential” to

The Project Manager  
SAFA Cumbria  
Best Life Building, 123 Botchergate  
Carlisle  
Cumbria, CA1 1RZ  
Tel: 01228 319711

Charity Number 1121122  
Company Number 6344630

Email: [north@safa-selfharm.com](mailto:north@safa-selfharm.com)

## **Guidance Notes**

SAFA is a charity committed to improving the mental health and emotional well-being of all individuals who self-harm.

SAFA is a team of qualified staff that is committed to making a positive difference to the lives of individuals aged 13+ who self-harm and to those who support them. Our primary goal is to empower the individual to take responsibility for their own lives by offering counselling and trusting support.

### **SAFA Offers:**

- **Assessment** Initially the client will be seen for an assessment to evaluate their needs and to consider what would provide them with the most benefit.
- **One to One Counselling** Working in relationship with the client to address their needs and to empower them to discover new ways forward.
- **Support** We offer on-going support that is appropriate to the individual's needs; to those that are either not ready or unable to engage in the counselling process. We also provide support following counselling, enabling future guidance if needed.
- **Family Support** We offer group support for the families and friends of the client.

### **Involvement with other organisations, link person if known**

Please give contact names and details of any other support staff that are involved with the individual being referred.

### **Data Protection**

The information is held in accordance with the DATA PROTECTION ACT (1998) and THE FREEDOM OF INFORMATION ACT (2007) for the purpose of work in conjunction with the organisation.

**Please return the completed form to the name and address given above.**



## Referral Form

### ***Personal Information***

<b>Last Name</b>		<b>First Name</b>	
<b>Date of Birth</b>		<b>Age</b>	
<b>Address</b>			
<b>Town</b>		<b>Postcode</b>	
<b>Residential Situation</b> (e.g. living alone, partner, flat share, etc.)			
<b>Tel. Number</b>		<b>Mobile Number</b>	
<b>Preferred Method of Contact</b> (detail below)			
<b>Email</b>			
<b>Mobile</b>		<b>Landline</b>	

### ***Support Information***

<b>G.P. Name</b>		<b>G.P. Tel. Number</b>	
<b>G.P. Address</b>			
<b>Mental Health Worker</b>		<b>Contact Details</b>	
<b>Current Support</b>			

### ***Medical Information***

<b>Does the client have any medical problems that we should be aware of?</b>	<b>Yes/No</b> If yes, please give details below.
<b>Is the client currently prescribed medication to help with their psychological problem(s)?</b> If yes, please indicate type of medication.	<b>Yes/No</b> Please specify.
<input type="checkbox"/> Anti-psychotics (nueroleptics/major tranquillizers) <input type="checkbox"/> Anti-depressants <input type="checkbox"/> Anxiolytics/Hypnotics (minor tranquillizers) <input type="checkbox"/> Other	
<b>Is the client substance abusing?</b> (For example: alcohol, drugs, medication or other substances)	<b>Yes/No</b> If yes, please give details below.
Please list substance abused/mis-used, age abuse started, frequency of abuse, whether injecting, history of overdoses.	

**This form is confidential when completed.**



Is the client being seen by any therapist, psychologist or psychiatrist?		Yes/No		
		If yes, please give details below.		
<b>In your opinion, is the client a risk to themselves or to others?</b>				
<b>Risk</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Suicide				
Self-harm				
Harm to others				
<b>Has a risk assessment been completed?</b>		<b>Yes/No</b>		
<b>If yes, is this attached?</b>		<b>Yes/No</b>		

### ***Additional Information***

Please use the box below to provide any additional information you would like us to be made aware of.

### ***Shared Information Consent (to be signed by client)***

I give consent for information to be shared between SAFA and the organisation specified below, when it is deemed <b>in my best interest</b> to do so.	
<b>Signature of client</b>	<b>Date</b>

### ***Referral Information***

<b>Name of Surgery or Organisation</b>			
<b>Address</b>			
		<b>Postcode</b>	
<b>Telephone Number (s)</b>			
<b>Print Name</b>	<b>Signature</b>	<b>Date</b>	

**This form is confidential when completed.**