Murray Hall Community Trust
Breaking Silence (01902 826 308)
The Bridge
St Marks Road, Tipton
DY4 0SL

Breaking Silence

Request for services form

ID NO:		
G	A	R

Child's / Young person's details		
Full Name: ……		
Male ☐ **Female** ☐	**Date of Birth**:	**Age:**
Full Address: …… …… **Postcode:** ……..		
Contact numbers: (Home)	(Mobile)	
Ethnicity:		
Main language spoken of child/Young Person:		
Religion:		
Name of School/college:…….. **School / College Address**: …….. …… **Contact number**:…….. Is the child on a **SEN** Register: Yes ☐ No ☐		
GP Name / Address: …… ……		
ECAF number (if known): ……		
An element of the therapy will require a Nominated Adult to be involved it is important that both parents and they are aware of the referral and are contactable. **Name of Parent / Guardian**:……... **Contact Details**: Telephone: …… Address if different from above:…… **Are parents / carers aware of referral:** Yes ☐ No ☐ If not why? …… **Who does the client live with?** …… …… …… ……		

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Who is the **Nominated Adult** who shall attend the final sessions **(Please note that this person must be over the age of 18 years):**

Name:……
Relationship to young person: …….
Contact Telephone: ……
Contact Address: ……

Referrer Details	
Full name: ……	
Role / Relationship with young person: ……	
Your Agency / Organisation Address: …….. ……..	
Phone Number:	**Email:**
Date referral completed and submitted:	

Further details	
Is the young person on a child protection plan?	Yes/No
Is the client accessing CAMHS?	Yes/No
Does the young person have any disabilities?	Yes/No
Is the young person on any medication?	Yes/No
Are the police currently involved?	Yes/No
Has the young person accessed counselling/therapy before?	Yes/No
Have the social services been involved with the client in the past?	Yes/No
Are health and social care involved with the young person?	Yes/No
Has there been an attempt to self-harm in the last 3months?	Yes/No
If you have answered yes to any of the above please elaborate:	

Nature and details of Self harm
Please record past issues & problems / difficulties they are presenting currently (PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE).

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RISKS: Please outline any known **risks to self or others**, and state if these are **current or historical**. Risks can include: suicidal attempts/thoughts; substance misuse; violence to others; inappropriate/risky sexual behaviours.

Known risks: To self and others	**Time line: Y/N** Current/ Historical
How often do they self-harm? (If known)	
Does the client have any suicidal thoughts?	
Has there been an attempt to take their own life in the last 6months? (If yes please give details)	
Is there any risk to staff? (If yes please give details)	
Are there any other issues we should be made aware of? (ie. Substance misuse, history of abuse, mental health, family violence, bereavement and loss, police involvement, child protection) *Please use a continuation sheet if required.*	

Other key professionals involved in supporting the client
Name of organisation:
Contact name:
Address:
Phone number:
Email address:

Name of organisation:
Contact name:
Address:
Phone number:
Email address:

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Preferred method of contact for liaison / appointments	
Referrer ☐ **Parent** ☐	Phone ☐ Post ☐ E-mail ☐
Preferred location / venue for appointments	
MHCT Office ☐ School ☐ Local Children's Centre ☐ Other:……	

CONSENT: Please note that consent shall be **required to process** the **referral** request. If a referral is sent via email or telephone an electronic signature shall have to be sent for the supporting consent. Alternately a paper copy can be sent to the MHCT office.

Young Persons Consent for Counselling / Therapy 7-18 years

You have the right to withdraw/change your mind at any time, including after you have signed this form.

I agree to Breaking Silence supporting me and I **confirm** that I fully **understand** the nature of support I will be receiving.

I understand that I will have the opportunity to discuss the details of the support with the Counsellor or Therapist before the sessions begins.

Name (Print):…… **DOB**: ……

Signature: …… **Date**: ……

Parent/Carer (**if under 13 years**)

Name: …… Signature: ……

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Please note that without GDPR consent Breaking Silence shall not be able to accept a referral.

Data Protection 2018 & GDPR Statement

The information that you provide will be stored securely on the Murray Hall Community Trust/CTS database and the information will only be shared with appropriate organisations/agencies for the purpose of providing you with support or offering services to you.

We will process your data fairly, lawfully and transparently for the purposes of providing you support services. We will store your data for as long as you remain a service user, thereafter it will be destroyed in line with our organisations retention policy unless regulations override this.

** I agree for my personal information to be shared with appropriate organisations for the purpose of providing me support or offering services to me ◯ **TICK**

** I agree for Murray Hall & its services to contact me ◯ **TICK**

I understand I can withdraw my consent at any time by contacting you in writing.

NAME (print): …… **Signature**: ……..

Date: ……..

State if Parent/Guardian/Carer is signing on their behalf: ……

For Office use		
Date referral reviewed by Project Lead Assessor:		
Referral accepted for **121 CTS**	**Yes / No**	Assessment date booked:
Alternative service referral		
Service	***Date of referral***	***Project lead signature***
Breaking Silence workgroups		
Creative coping		
External agency:…….. ……		