**SELF REFERRAL FORM**

ACTS FAST provides support for non-abusive parents /carers and adult family members of children who have suffered Child Sexual Abuse (CSA) or sexual assault and adult family members and partners of individuals who have accessed Indecent Images of Children (IIOC)

***ACTS FAST will not work with someone currently being investigated for, or who has been convicted of child sexual abuse, sexual violence, sexual assault, domestic abuse or accessing Indecent Images of Children (IIOC).***

We currently have three support services available for our clients which are offered weekly face to face or online:

* Our one to one **Trauma Support Service** which is up to 10 weeks.
* Our one to one **Counselling Service** which is up to 24 weeks.
* Our **Brighter Futures Peer Led Support Groups** which is 8 weeks.

All our clients have to first complete our Trauma Support Service before accessing our Counselling Service and our Peer Led Support Groups.

|  |
| --- |
| Date  |

**Your Details**

|  |  |
| --- | --- |
| Name:  | DOB:  |
| What pronouns do you like to be known by: |
| Address: Postcode:  |
| Telephone:  | OK for voicemail or text messages? | Yes [ ]  | No [ ]  |
| E-mail:  | OK to send you email? | Yes [ ]  | No [ ]  |
| Preferred contact:  | Telephone [ ]  | Email [ ]  | Post [ ]  |  |

**I consent for my details to be shared with the ACTS FAST Team** (please tick the box): **Yes** [ ]

**Emergency contact**

|  |
| --- |
| Name:  |
| Mobile:  | Home Number: |
| Relationship to you:  |

**Details of children, please complete if applicable.**

|  |  |
| --- | --- |
| How many children do you have? |  |
| Please provide details of the child(ren) and identify which child(ren) has suffered the sexual abuse or sexual assault: |
| Child’s name:  | Age: | Sexually Abused: Yes [ ]  | No [ ]  |
| Child’s name: | Age: | Sexually Abused: Yes [ ]  | No [ ]  |
| Child’s name: | Age: | Sexually Abused: Yes [ ]  | No [ ]  |
| Child’s name: | Age: | Sexually Abused: Yes [ ]  | No [ ]  |
| Is the child(ren) currently living with you?  | Yes [ ]  | No [ ]  |  |

**Details of event(s)**

|  |
| --- |
| When did the event / incidents happen? |
| Please provide an overview of the incident/event: |

**Relationship of the offender to yourself**

|  |  |  |  |
| --- | --- | --- | --- |
| Husband [ ]  | Partner [ ]  | Ex-partner [ ]  | Family friend [ ]  |
| Relative [ ]  | Acquaintance [ ]  | Parent [ ]  | Other [ ]  |
| If ‘Other’ please provide details:  |

**Details of Criminal Justice System and / or Family Court Involvement**

|  |
| --- |
| Please give details if there is or has been a Police investigation, Family Court involvement and / or criminal proceedings. |

**Additional information**

Have you experienced any of the following?

|  |  |  |
| --- | --- | --- |
|  | Current | Past |
| Mental health vulnerabilities | Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  |
| Learning / Processing difficulties | Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  |
| Physical disabilities | Yes [x]  | No [ ]  | Yes [ ]  | No [ ]  |
| Alcohol misuse | Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  |
| Drug misuse | Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  |
| Experienced domestic abuse | Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  |
| Experienced sexual violence | Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  |
| Currently receiving counselling elsewhere or on a waiting list | Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  |
| If ‘Yes’ to any of the above, please provide brief details: |

**Details of GP**

|  |
| --- |
| Please provide details of your GP and GP Surgery: |
|  |

Please provide details of any other professionals you are currently engaged with or getting support from. This helps us understand how we might fit into your support network. For example Social Services, CMHT, The Police etc.

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Organisation: |  |
| Contact Tel: |  | Contact e-mail: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Organisation: |  |
| Contact Tel: |  | Contact e-mail: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Organisation: |  |
| Contact Tel: |  | Contact e-mail: |  |

|  |
| --- |
| Brief details of the overall family situation and what is going on for you at the moment: |

**When completed please e-mail to: support@actsfast.org.uk**

**NOTES & INFORMATION**

*For our support services we require clients to be in a safe place and ready and able to engage with our support. This means there are exceptions to who we can support within our services.*

*We will not work in any of our services with the following clients:*

* *Someone who is receiving therapy from another organization, we ask that you stop or put on hold other therapeutic support whilst we are working with you.*
* *Someone with severe mental health vulnerabilities.*
* *Someone with an active substance dependency (alcohol/drugs).*

*Our Counselling Service and Brighter Futures Peer Led Support Group will not work with any client who is:*

* *Currently living in a refuge*
* *Currently in a domestic abuse relationship*
* *We are unable to work with individuals who are pregnant, support will not begin until the baby is 6 months old.*

*If you are not ready for our services we will, where we can, signpost and help*

*you get the support you need.*