

**CONFIDENTIAL SISTER SYSTEM SELF-REFERRAL FORM**

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**WE ARE UNABLE TO PROCESS YOUR REFERRAL UNTIL WE RECEIVE THIS FORM FULLY COMPLETED**

**PERSONAL DETAILS:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:**  |  | **DOB:**  |  |
|  |  |  |  |
| **Referral date:**  |  | **Address:**  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Sexual Orientation:**  |  | **Contact Number:**  |  |
|  |  |  |  |
| **Ethnicity:**  |  | **E- mail:**  |  |
|  |  |  |  |
| **Immigration status:**  |  | **How did you hear of Sister System?**  |  |

**A person you would like contacted in case of emergency:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:**  |  | **Relationship to you:**  |  |
|  |  |  |  |
| **Contact Number:**  |  | **Address (Optional):**  |  |

## **KEY INFORMATION:**

|  |
| --- |
| **Place of Residence (kindly tick relevant box)**  |
|  |
|  |
| **Independent Accommodation** [ ]  | **Family Home** [ ]  | **Children’s Home** [ ]   |
|  |  |  |
| **Semi-independent accommodation** [ ]  | **Foster Care** [ ]  | **Other:**  |

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| --- |
| **Please give details of any other agencies currently working with you:** |
| **Agency** | **Lead Person** | **Email Address** | **Phone Number** |
|  |  |  |  |
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|  |  |  |  |
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| --- |
| **Medical Contact Details:**  |
|  |
|  |  |
| **GP Name and Address:** |  | **Contact Number:** |  |
| **Health Visitor’s Name and Address** |  |  **Contact Number:**  |  |
|  |  |  |  |

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| **Are you a survivor of?**  |
| **Child Sexual Exploitation** [ ]  | **Domestic abuse** [ ]  | **Teenage pregnancy** [ ]  |
|  |  |  |
| **Mental health issues** [ ]  | **Substance abuse** [ ]  | **Learning disabilities** [ ]  |
|  |  |  |
| **Post-natal depression** [ ]  | **Child Criminal Exploitation** [ ]  | **Drug trafficking** [ ]  |
|  |  |  |
| **Sex Trade** [ ]  | **Controlled or coerced** [ ]  | **Modern slavery** [ ]  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
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| --- | --- | --- |
| **Rape** [ ]  | **Physical Abuse**[ ]  | **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** [ ]  |
|  |  |  |

**Have you ever experienced?**  |
| **Depression** [ ]  | **Anxiety**  [ ]  | **Bipolar** [ ]  |
|  |  |  |
| **Extreme Stress** [ ]  | **Hypermania**  [ ]  | **Loneliness** [ ]  |
|  |  |  |
| **Anger**  [ ]  | **Bereavement**  [ ]  | **Panic Attacks** [ ]  |
|  |  |  |
| **Sleeplessness** [ ]  | **Anything else? *(Please note)*** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |

## **PERSONAL NEEDS**

So that we can offer the most appropriate support, and match the most suitable coaches, please complete the following table. Please note this is not a ‘points’ system. Answers will not be prioritized based on how many categories are ticked. This information, will be used to monitor how our support best meets your needs and expectations. *\*\*If you are unsure at this stage, do not worry we can discuss this together\*\**

|  |  |
| --- | --- |
| **Identified Need** *(please tick all that apply)* | **Why is this a need?** |
|  |  |
| **Resilience development** [ ]  |  |
|  |  |
| **Risk awareness** [ ]  |  |
|  |  |
| **Career/training development** [ ]  |  |
|  |  |
| **Family needs** [ ]  |  |
|  |  |
| **Managing your behaviour** [ ]  |  |
|  |  |
| **Being involved in the child(ren)’s development** [ ]  |  |
|  |  |
| **Coping with own physical health** [ ]  |  |
|  |  |
| **Coping with own mental health** [ ]  |  |
|  |  |
| **Coping with feeling isolated** [ ]  |  |
|  |  |
| **Parent’s self-esteem** [ ]  |  |
|  |  |
| **Coping with your physical health** [ ]  |  |
|  |  |
| **Coping with your mental health** [ ]  |  |
|  |  |
| **Managing the household budget** [ ]  |  |
|  |  |
| **The day-to-day running of the house** [ ]  |  |
|  |  |
| **Stress caused by conflict in the family** [ ]  |  |
|  |  |
| **Coping with multiple birth/multiple children under 5** [ ]  |  |
|  |  |
| **Use of services** [ ]  |  |
|  |  |
| **Other (please describe)** [ ]  |  |

**Do you think you have challenges with drugs or alcohol?** yes/no *(please indicate)*

If ‘yes’ which drugs please specify: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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| --- |
| **MORE ABOUT YOURSELF****Please state if you are:**  |
| **In School**  [ ]  | **In College**  [ ]  | **At University**  [ ]  |
|  |  |  |
| **Not in Education or Training** [ ]  | **Unemployed** [ ]  | **Employed** [ ]  |

**Do you have any hobbies and/or interests? (Please share with us)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What support do you think you would need from Sister System? (If you are unsure at this stage don’t worry, we can discuss this).**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What programme/s interests you (please refer to website: sistersystem.org for more information)?**

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**Can you tell us how the care system has affected you?**

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## **ADDITIONAL INFORMATION:**

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| --- |
| **Please add any background information that you think is important for us to know.** *(If you would like to speak with us about any of the above, that's also fine).*  |
|  |

## **SIGNATURE & DECLARATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Signature:** |  | **Date:** |  |
|  |  |  |  |  |  |

***Thank you for completing this self-referral form, please email it to*** ***programmes@sistersystem.org*** ***or alternatively post it to our offices, address at the top of this form.***

|  |
| --- |
| Next Steps - On receipt of this referral please expect a phone call within 5 days/unless urgent from one of our sisters who will arrange to speak with you which can either be done remotely or social distancing face-face. |