Adult self-referral form (18+)

We recognise that reaching out for support is a courageous and important step. Please complete this form as fully as you can. Once finished, please send it to **referrals@glosrasac.org.uk**

We will then be in touch to confirm receipt of your referral and arrange an initial assessment to better understand your needs and help guide you toward the most appropriate support.

|  |  |  |  |
| --- | --- | --- | --- |
| Date |  | Have you received GRASAC support before? | Yes  No  Unsure |
| **GRASAC confidentiality statement:**  **The information shared with GRASAC is confidential and will only be shared within the organisation where relevant.**  ***We will only break confidentiality if: -***   * ***If you request us to.*** * ***If you’ve given us identifying information and we are concerned for your safety.*** * ***If you are a child at risk, or giving us identifying information about a child at risk.*** | | | |
| **Have you read and understood our confidentially statement?** Yes  No  If you do not understand, please don’t worry, reach out to us, and we can explain it to you (01452 305421).  We work in partnership with Gloucestershire Counselling Service (GCS) and may need to securely share your information with them to help identify the best support pathway for you.  **Do you consent for us to share this information with GCS?**  Yes  No  We cannot accept third party requests for support. If you are concerned for someone and would like to talk through our support options, please give us a call **01452 305421.** Alternatively, contact Rape Crisis England and Wales (RCEW) national helpline on **0808 500 2222.**  **I would like support and can confirm I am filling this form in for myself** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Your details** | | | |
| Full Name |  | | |
| Date of Birth |  | Preferred Pronouns |  |
| How would you describe your gender? |  | Do you identify with the sex you were assigned at birth? | Yes  No  Unsure |
| How would you describe your ethnicity? |  |
| How would you describe your sexual orientation? | Bisexual ​☐​  Gay / Lesbian ​☐​  Heterosexual / Straight ​☐​  Other ​☐​  Prefer not to say ​☐​ | Preferred method of contact: | Phone  Email  Text |
| What is your religion or belief? |  | Is there anything related to your religion or beliefs, that we need to be aware of that would make you feel more comfortable when accessing support? |  |
| Contact number: |  | Safe to call and leave message? | Yes  No |
| Safe to text? | Yes  No |
| Email address: |  | Safe to email? | Yes  No |
| Postal address: |  | Safe to post? | Yes  No |
| Primary language: |  | Is an interpreter required? | Yes  No |

|  |  |  |  |
| --- | --- | --- | --- |
| **Main information** | | | |
| Have you experienced sexual violence any time in your life? | Yes  No  Unsure | | |
| Was that experience in the last 12 months? | Yes  No  Unsure | | |
| Please use this space to provide any more details you would like us to know (optional): |  | | |
| Do you have an open police investigation? | Yes  No  Unsure | | |
| Have you told anyone else? | Yes  No  Unsure | Details: |  |
| If you would like support around reporting, or if you have an open police investigation, we can refer you to the Independent Sexual Violence Advisor (ISVA) service provided by First Light by sending them the information provided on this referral form.  **Do you consent for us to share this information to First Light**?  Yes  No | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Do you have any health conditions, disabilities or access needs?** | | | |  |  | | Neurodivergence *(Autism/ ADHD)* | Yes  No  Unsure | Details: |  |  |  | | Physical disability | Yes  No  Unsure | Details: |  |  |  | | Specific learning need *(SpLD) (e.g dyslexia, dyspraxia)* | Yes  No  Unsure | Details: |  |  |  | | Mental Health condition *(depression/anxiety)* | Yes  No  Unsure | Details: |  |  |  | | Long term health condition | Yes  No  Unsure | Details: |  |  |  | | Sensory impairment *(hearing/ sight)* | Yes  No  Unsure | Details: |  |  |  | | Other | Yes  No  Unsure | Details: |  |  |  | | **Please provide details of any adjustments, access or support needs below:**  *e.g. If you have any accessibility needs which means a phone call would not be suitable, please let us know.* | | | |  |  | |  | | | |  |  | |

Thank you for completing our self-referral form. Please send this to [referrals@glosrasac.org.uk](mailto:referrals@glosrasac.org.uk) and we will be in touch via your preferred method of contact to arrange an initial assessment and talk through our services.