

**Client Referral Form**

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| --- | --- |
| Date of Referral  |  |

Client Information

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| --- | --- | --- | --- | --- |
| Client Name:  |  |  |  |  |
|   |  |  |  |
| Date of Birth:  |  |  | Gender:  |   |
|   |  |  |  |
| Parent/Guardian if under 18  |  |  |  |

|  |  |
| --- | --- |
| Address:     |   |

|  |  |
| --- | --- |
| Email:  |  |

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|  |  |
| --- | --- |
| Contact Telephone Number:  |  |

Referring Professional

|  |  |  |  |
| --- | --- | --- | --- |
| Name:  |  |  |  |
|   |  |  |  |
| Relationship to Client: |   |  |  |  |
|   |  |  |  |
| Organisation:  |  |  |  |
|   |  |  |  |
| Address:    |  |  |  |
|   |  |  |  |
| Telephone:  |  |  | Email:  |  |

A Registered Scottish Charity Number SC049922

First Tier provides trauma informed support to survivors of sexual abuse and complex trauma who have learning support needs, including survivors with

Autism Spectrum Disorder who are displaying inappropriate sexualised thoughts or behaviours. We offer a trauma-informed, person-centred approach, structured, one-to-one emotional support and provide practical support to help clients with integration back into the community

Reason for referral – Please be as specific as possible, this will help our team provide support tailored to the client’s needs.

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| Please describe past trauma  |
|          |

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| Does the client have any behaviours / triggers staff should be aware of – please summarise |
|      |

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| Does the client have any additional support needs – Please summarise  |
|  Learning Disability Mental Health Dyslexia / dyspraxia. AD/(HD) /ASD (Asperger’s / Autism) Physical disability Deaf / hard of hearing If yes, are you BSL or Makaton user Blind or partially sighted Other – please specify below

|  |
| --- |
| Please summarise – This will enable our staff to better support the client:   |

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| --- |
| Please Indicate if the client has any issues in relation to:  |
|   Alcohol  Drugs  Aggression  Self-harm

|  |
| --- |
| Please summarise – This will enable our staff to better support the client:   |

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| Does the client have any of the following – Please summarise  |
|  Problematic /Risky behaviours Offending Behaviours Criminal Convictions Other – please specify below

|  |
| --- |
|  Please summarise – This will enable our staff to better support the client:    |

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| --- |
| History of Offending |
| Does the client have any known convictions / sexual offences Yes No If yes, please provide details: |

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| --- |
| Does the client have any outstanding offences Yes No  |
| If yes, please provide details: |

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| --- |
| Additional Information |
| Is the client receiving support from any other Agency Yes No If yes, please provide details:Does the client have any issues relating to homelessness / accommodation Yes No If yes, please provide details: |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Client:  |  | Date:  |  |
|   |  |  |  |
| Signature of Referral Source:  |  | Date:  |  |

Please return completed referral form by post or email to Sharon McKinley

Mail: Orkney Street Enterprise Centre, 18 Orkney Street, Govan, Glasgow G51 2BX

Email: Referral@firsttier.org.uk

 **18 Brighton Place,**

 Ibrox, Glasgow, G51 2BX

 **Email**: referral@firsttier.org.uk

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