

**SELF-REFERRAL FORM**

Information to be provided by individual wishing to self-refer

Please return all forms to: info@assistni.org.uk

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| **Client name** Forename, Surname |  |
| **Client age** including date of birth |  |
| **Client address** including post code |  |
| **Client email address** |  |
| **Safe phone number:** In the instance of a child or young person under 18yrs or an adult at risk, the safe phone number of a designated appropriate adult. |  |
| **Preferred method of contact:** | **Phone E-Mail Text**  |
| **Preferred time of contact:** | **AM PM**  |
| **Nationality, ethnicity and first language**. Where English is not the first language, please indicate whether English is spoken or whether an interpreter is required |  |
| Abuse Details:Abuse description (domestic, sexual or domestic & sexual) |  |
| Date abuse **reported** to PSNIand date abuse **occurred:**Please provide crime reference number if known: |  |
| Are you impacted by any of the following? | Drug/alcohol/mental health issues/pregnancy.Physical/learning or communication difficulties. |
|  **Your message – How can we help?** |
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