

IMPORTANT INFORMATION FOR YOU TO CONSIDER AND RETAIN. PLEASE DO NOT RETURN WITH REFERRAL

SOUTH ESSEX RAPE & INCEST CRISIS CENTRE opened in 1984 and covers the areas of Thurrock, Basildon and Brentwood. As a voluntary organisation and a registered charity, the organisation is confidential and independent from social services, the police and other official agencies.

SERICC provides a service to women and girls aged 12 and over who have been or are at risk of being raped, sexually assaulted, experienced child sexual abuse, sexual harassment or who have experienced any form of sexually violence or attempted sexual assault.

SERICC Provides:

- ◆ Experienced and qualified sexual violence counsellors
- ◆ counselling sessions in a comfortable environment
- ◆ free, short term or long term 'one to one' and telephone counselling
- ◆ appointments with the same counsellor
- ◆ Information and support about police, court and medical procedures
- ◆ Support and advocacy with statutory agencies e.g. police, Dr's, social workers etc.

How to book an appointment?

When you ring for the first time we will offer to send you information and make an appointment to see a counsellor. Sometimes due to high demand for counselling there is a waiting list which will be explained to you when you call. (Girls under 18 years of age are prioritised and do not go onto the waiting list). You can continue to use the counselling telephone line until an appointment space becomes available or when you choose to start counselling.

The telephone counselling line is open 9 hours per week, so it can be busy. If you have difficulty in getting through please keep trying or leave a message on the answer phone and a counsellor will phone you back.

How to make a referral

Referring agencies should be aware that some services users may require support in contacting SERICC. They may not have the confidence to make first contact or may not know what to expect.

Referring agencies need to complete a referral form that can be downloaded from our website www.sericc.org.uk. You can also request the form to be faxed or emailed to you. The form must be sent to SERICC before the referral can be accepted; this will enable SERICC to process the referral as quickly as possible.

Referring agencies must inform SERICC of any known risks to or from the service user. SERICC may only disclose information to the referrer about the service user's attendance with written permission from all parties. SERICC will not disclose issues discussed within counselling sessions without the written consent of the service user.

SERICC will only accept referrals for women and girls who have agreed to attend and who are aware that the referral has been made.

- Service Users will be a **minimum** of 12 years old and have experienced sexual violence at any time of their lives
- Service Users will reside or work in Thurrock, Basildon, Billericay, Wickford and Brentwood areas
- Men & Boys after initial telephone assessment will be referred to appropriate men's services.
- Service users will be referred on for additional support if SERICC feels that additional support services are necessary and appropriate.
- SERICC must be informed by the referrer of the service user's involvement with Social Services, Probation Services or Mental Health Services. This is particularly important if the service user is involved in care proceedings
- **Confidentiality** If someone gives us information over the phone which suggests that they or another person is at serious risk of immediate harm, SERICC will support them to access services. In the most exceptional circumstances, if they have provided personal details such as a name and address, SERICC may need to make a decision to breach confidentiality, in order to protect them or another person.

REFERRAL FORM

Please confirm that it is safe to contact the client by telephone or send literature by post and that they are aware of the referral. If it is not safe then please provide alternative safe contact details.

*Please delete as appropriate

REFERRING ORGANISATION:		WORKER'S NAME:																											
WORKER'S TEL NO.		REFERRAL DATE:																											
CLIENT'S NAME:		CLIENT'S CONTACT NO.																											
CLIENT'S ADDRESS:																													
TOWN:		POST CODE:																											
ALTERNATIVE SAFE CONTACT DETAILS:																													
CLIENT AGE:		AGE AT TIME OF ASSAULT:																											
ETHNIC GROUP:		LANGUAGE:																											
INTERPRETER REQUIRED? YES / NO*		IMMIGRATION STATUS:																											
MARITAL STATUS:		NUMBER OF DEPENDENTS:	MALE	FEMALE																									
EMPLOYMENT STATUS:		ACCOMMODATION STATUS:																											
LIVING WITH: ALONE / PARTNER / CHILDREN / RELATIVE / CARER*																													
<p>CLIENT DISABILITY: If a client considers themselves to have a disability please select the most appropriate definition. If the client has multiple disabilities please select the definition that reflects the predominant disability.</p> <table border="0"> <tr> <td>Not Considered Disabled</td> <td><input type="checkbox"/></td> <td>Mental Health Issues</td> <td><input type="checkbox"/></td> <td>Other</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Physical Impairment</td> <td><input type="checkbox"/></td> <td>Learning Disability/Difficulty</td> <td><input type="checkbox"/></td> <td>Unknown</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sensory Impairment</td> <td><input type="checkbox"/></td> <td>Long Standing Illness or Health Condition</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Other (please state)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>						Not Considered Disabled	<input type="checkbox"/>	Mental Health Issues	<input type="checkbox"/>	Other	<input type="checkbox"/>	Physical Impairment	<input type="checkbox"/>	Learning Disability/Difficulty	<input type="checkbox"/>	Unknown	<input type="checkbox"/>	Sensory Impairment	<input type="checkbox"/>	Long Standing Illness or Health Condition	<input type="checkbox"/>			Other (please state)					
Not Considered Disabled	<input type="checkbox"/>	Mental Health Issues	<input type="checkbox"/>	Other	<input type="checkbox"/>																								
Physical Impairment	<input type="checkbox"/>	Learning Disability/Difficulty	<input type="checkbox"/>	Unknown	<input type="checkbox"/>																								
Sensory Impairment	<input type="checkbox"/>	Long Standing Illness or Health Condition	<input type="checkbox"/>																										
Other (please state)																													
<p>STATUTORY FRAMEWORKS DOES THE SERVICE USER HAVE ANY INVOLVEMENT WITH THE FOLLOWING:</p> <table border="0"> <tr> <td>MARAC</td> <td><input type="checkbox"/></td> <td>Probation / Youth Offending</td> <td><input type="checkbox"/></td> <td>CAF</td> <td><input type="checkbox"/></td> </tr> <tr> <td>MAPPA</td> <td><input type="checkbox"/></td> <td>Care Management</td> <td><input type="checkbox"/></td> <td>Homeless</td> <td><input type="checkbox"/></td> </tr> <tr> <td>ASBO</td> <td><input type="checkbox"/></td> <td>Care Programme Approach</td> <td><input type="checkbox"/></td> <td>Other</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Drug Intervention</td> <td><input type="checkbox"/></td> <td>Child in Need</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> </table>						MARAC	<input type="checkbox"/>	Probation / Youth Offending	<input type="checkbox"/>	CAF	<input type="checkbox"/>	MAPPA	<input type="checkbox"/>	Care Management	<input type="checkbox"/>	Homeless	<input type="checkbox"/>	ASBO	<input type="checkbox"/>	Care Programme Approach	<input type="checkbox"/>	Other	<input type="checkbox"/>	Drug Intervention	<input type="checkbox"/>	Child in Need	<input type="checkbox"/>		
MARAC	<input type="checkbox"/>	Probation / Youth Offending	<input type="checkbox"/>	CAF	<input type="checkbox"/>																								
MAPPA	<input type="checkbox"/>	Care Management	<input type="checkbox"/>	Homeless	<input type="checkbox"/>																								
ASBO	<input type="checkbox"/>	Care Programme Approach	<input type="checkbox"/>	Other	<input type="checkbox"/>																								
Drug Intervention	<input type="checkbox"/>	Child in Need	<input type="checkbox"/>																										

PLEASE NAME THE ANY OTHER ORGANISATIONS OR WORKERS INVOLVED IN THE SERVICE USERS WELFARE:

ARE YOU AWARE IF THE WOMAN HAS PREVIOUSLY USED SERICC'S SERVICES?

YES

NO

PLEASE LIST ANY FURTHER INFORMATION OR ISSUES RELEVANT TO THIS REFERRAL:

TYPE OF ASSAULT – IF KNOWN

SEXUAL VIOLENCE

CHILDHOOD SEXUAL ABUSE

RAPE

Ways to Return this Form

BY FAX: 01375 387053

BY POST: The Hall, West Street, Grays, Essex RM17 6LL

BY EMAIL: sericc@sericc.org.uk

FOR OFFICE USE ONLY

- | | | |
|---|--------------------------|-------|
| 1. Referral Acknowledgement Sent | <input type="checkbox"/> | Date: |
| 2. Referral Logged on Database | <input type="checkbox"/> | Date: |
| 3. Copied to All Referrals File | <input type="checkbox"/> | Date: |
| 4. Client Contacted | <input type="checkbox"/> | Date: |
| 5. Client Requested to be put on Waiting List | <input type="checkbox"/> | Date: |
| 6. Referral in Waiting List File | <input type="checkbox"/> | Date: |