

**Room to Heal**

**Referral and Consent Form - Therapy Group**

Thank you for your interest in Room to Heal. Room to Heal is a therapeutic community and human rights charity supporting asylum seekers and refugees who have survived torture and organised violence. We offer weekly mixed-gender group therapy, as well as social activities and casework support in a non residential community. Our groups run at our office and therapy rooms in Newington Green, London N16.

If you would like to refer someone who would benefit from our services, or if you would like to refer yourself, please ensure that you:

* **Complete all sections of this referral** and **consent form**
* **Submit relevant documents** regarding your / client’s asylum case and medical situation i.e. **witness statements, refusal letters, medical/psychiatric reports.**

Please read the **following** **criteria** before referring to Room to Heal. The person being referred should:

* To be seeking asylum or have received refugee status or leave to remain.
* To have survived torture (or a direct family member who due to their close relationship were directly affected at the time of the event) or trafficking in one’s home country and to have a well-founded fear of return.
* Be willing and able to engage in **mixed-gender group therapy** (either a group that runs for a year, or a group that is longer term).
* **Be available to take part in our therapy group. We run groups on Tuesdays (11.30am-1pm, rolling intake) and Thursdays (11.30am-1pm, annual intake).**
* Living in Greater London.
* Have a **good level of English**. Our groups are run in English due to the large mix of nationalities and languages at Room to Heal. This is so that members are able to relate directly with one another and participate fully.
* **Be aged 21 or over.** People below this age will benefit more from an organisation that specialises in working with younger age groups.
* Be willing to be **part of a community**. Room to Heal values community as a mutually supportive means towards healing and we hold weekly community events in person on Friday afternoons.

It is important to note that Room to Heal is not a crisis service. If an individual is in a mental health crisis or actively suicidal, please refer to the local crisis service, Community Mental Health Team, or phone NHS urgent mental health helplines. Please also note that Room to Heal has a Duty of Care to people assessed by our service. **There may be exceptional circumstances in which there is a significant concern of a risk of serious harm to a person being assessed or another person. In such an event, it may be necessary for information to be shared outside of Room to Heal with other professionals (e.g. a doctor). Wherever possible, the service would seek consent of the person referred.**

**How to refer**

If you feel that Room to Heal is the right environment for your client, please send the completed referral form, consent form and relevant documentation to [admin@roomtoheal.org](mailto:admin@roomtoheal.org) and we will get back to you as soon as possible. Thank you.

**Referral Form**

**Please complete all sections and submit any relevant documents regarding the client's asylum case and medical situation.**

| **Referral** | |
| --- | --- |
| Self-referral | ☐ Yes ☐ No (If “no”, please answer the following questions) |
| Referrer’s name |  |
| Organisation |  |
| Contact phone |  |
| Contact email |  |
| Relationship to client |  |
| Reasons for referral to Room to Heal (Please include any physical or psychological health issues) | |
| What would the individual like to gain by joining Room to Heal? | |
| Room to Heal members are expected to engage fully with our communal therapeutic activities and mixed-gender therapy groups. How do they feel about this, and what challenges do they foresee? | |
| Is there a preference in joining a therapeutic group that is time limited (for 1 year) or a longer-term group - please provide as much detail as possible as to why one is preferred over the other? | |

| **Date of referral** |  | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal information** | | | | | | | | |
| First name: |  | | | Surname: |  | | | |
| Gender eg  Male / Female / Transgender / Non Binary /Intersex / Self Describe / or Prefer not to say |  | | | Date of Birth: |  | | | |
| Address: |  | | | Email: |  | | | |
| Phone: |  | | | Mobile: |  | | | |
| Emergency contact name and relationship: |  | | | Emergency contact number: |  | | | |
| English speaking ability: |  | | | Other languages: |  | | | |
| Religion |  | | | Sexual orientation (optional) |  | | | |
| Do you have a disability, if so please provide details here and if you have any specific access issues? |  | | | | | | | |
| Do you have any food allergies, please provide details here? |  | | | | | | | |
| **Required to join therapeutic support groups:** | | | | | | | | |
| One of our therapeutic support groups takes place weekly on **Tuesdays (11.30am-1pm) at our office in Newington Green, Islington**. Is the individual available at this time? | | | | | | | Yes | No |
| Our other therapeutic support group takes place weekly on **Thursdays (11.30am-1pm) at our office in Newington Green, Islington.** Is the individual available at this time? | | | | | | | Yes | No |
| Our therapeutic support groups are run in **English** due to the variety of languages represented within Room to Heal. Does the individual speak a sufficient level of English to engage fully in the therapeutic support group and understand others? | | | | | | | Yes | No |
| Is the individual willing to take part in a mixed-gender group therapy? | | | | | | | Yes | No |
| If the individual has a child/ren, do they have someone to provide childcare during the group (leave blank if no childcare responsibilities)? | | | | | | | Yes | No |
| Have you obtained consent from the person you are referring to Room to Heal?  ***(Please complete consent form that follows on from this referral form)*** | | | | | | | Yes | No |
|  | | | | | | | | |
| **Immigration history** | | | | | | | | |
| Country of origin |  | | Stage of current application: first claim awaiting decision / appeal / fresh claim | | |  | | |
| Immigration status |  | |
| HO ref number |  | |
| NASS ref number |  | | Date of arrival in UK | | |  | | |
| Initial claim – date; outcome; reasons if refused |  | | | | | | | |
| Details of appeals / fresh claims |  | | | | | | | |
| If you have been a victim of trafficking, have you been referred to the National Referral Mechanism and if so please provide details of your current status and any decision dates |  | | | | | | | |
|  |  | | | | | | | |
| **Detention history** | | | | | | | | |
| Name of immigration Centre, arrival date and release date |  | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
|  | | | | | | | | |
| **Human rights violations** | | | | | | | | |
| Experience of human rights violations  ☐Assault  ☐ Child Soldiers  ☐ Domestic/family violence  ☐ Ethnic/racial/social persecution  ☐ Extreme physical/psychological violence  ☐ Female genital mutilation  ☐ Forced Marriage  ☐ Gang based/inter-tribal/inter-clan violence  ☐ Honour killings (threatened/attempted) | | ☐ Political persecution  ☐ Rape  ☐ Religious persecution  ☐ Gender based persecution  ☐ Sexuality based persecution  ☐ Slavery  ☐ Solitary confinement  ☐ Trafficking  ☐ Violations of liberty  ☐ Witness to atrocity | | | | | | |
| Other/Comments: | | | | | | | | |
| Please give a history of your client’s experiences of human rights violations | | | | | | | | |

| **Immigration legal Support / Representative** | | | |
| --- | --- | --- | --- |
| Name |  | Firm / Organisation |  |
| Address |  | Legal aid/private? |  |
| Phone |  |
| Email |  |

| **Other legal Support / Representative (e.g. housing)** | | | |
| --- | --- | --- | --- |
| Name |  | Firm / Organisation |  |
| Address |  | Phone |  |
| Email |  |

| **Medical contact** | | | |
| --- | --- | --- | --- |
| Name of GP |  | GP Surgery |  |
| Address |  | Phone |  |
| Email |  |

| **Physical Health History** | | |
| --- | --- | --- |
| Please provide summary of physical health conditions  Continue overleaf if necessary |  | |
| Medication (current and previous) |  | |
|  | |

| **Covid-19 health and safety** |
| --- |
| Health conditions (please tick all that apply\*):   * Down’s syndrome * certain types of cancer or have received treatment for certain types of cancer * sickle cell disease - high chance that his children will have sickle cell * certain conditions affecting their blood * chronic kidney disease (CKD) stage 4 or 5 * severe liver disease * an organ transplant * certain autoimmune or inflammatory conditions (such as rheumatoid arthritis or inflammatory bowel disease) * HIV or AIDS who have a weakened immune system * inherited or acquired conditions affecting their immune system * rare neurological conditions: multiple sclerosis, motor neurone disease, Huntington’s disease or myasthenia gravis   *\*Please note that having one or more of these conditions has no impact on your referral. We collect this information to ensure that, where possible, measures are taken to protect those who are most vulnerable to complications from Covid-19.* |

| **Psychiatric History** | | | | | |
| --- | --- | --- | --- | --- | --- |
| Please detail previous and recent contact with psychiatric services (including name / contact detail of services / in-patient / out-patient, and dates treated)  Continue overleaf if necessary | | |  | | |
| Medication (current and previous) | |  | | | |
| Any history of alcohol or drug abuse. Please give details | |  | | | |

| Ri**Risk factors** |
| --- |
| Any urgent / risk factors to be considered (e.g. level of trauma being exhibited,  suicidal tendencies and suicide attempts) |

| **Current / previous therapeutic support** | |
| --- | --- |
| Name of therapist |  |
| Contact details |  |
| Duration of therapy |  |
| Further details of any previous therapeutic support | |
|  | |
|  | |
| **Support network** | |
| Accommodation |  |
| Financial support |  |
| Other organisations supporting |  |
| Other family, friends |  |

| **Criminal convictions** | |
| --- | --- |
| Give details if client has any criminal convictions |  |

| **Any other comments:** |
| --- |



**Referral Consent Form**

Name: ………………………………………

Date: \_\_/\_\_/\_\_\_\_

Room to Heal is committed to maintaining your confidentiality at all times. We comply with the Data Protection Act (2018) and the General Data Protection Regulation (GDPR). In order to be able to support you, Room to Heal needs to store, share and protect your data in a number of ways. To do this, we require your consent.

**Please read the following sections carefully, and let us know that you understand and agree by ticking the box in each section, and signing your name and date at the end of this form.**

**1. Referral**

I give consent to Room to Heal to hold all my personal information that is provided to them now and in future for the purpose of Room to Heal being able to provide me with therapeutic and casework assistance. All of my personal and sensitive data will be stored securely within Room to Heal. I understand that Room to Heal will need to process my personal data to provide me with casework assistance and therapy.

**Yes ☐ No ☐**

**2. Sharing information about me with my referrer**

Room to Heal may need to speak to -and share information about me- with my referrer, to let them know whether my referral was successful, or to ask for further information. Room to Heal will also work to communicate with me about further information required.

**Yes ☐ No ☐**

**3. Using my information to help Room to Heal raise funds and improve its services**

Room to Heal shares anonymised details of their work with people and organisations - for example funders - so that they may choose to support the charity. This is called research information. For example, Room to Heal will tell them how our services support our members, how many people they help, how many attend initial assessments, and how many people join the therapy groups. When they do this, they do not give any information to anyone that will identify me, such as my name or my address, without my permission.

**Yes ☐ No ☐**

**4. Using my contact details to get in touch with me and invite me to an appointment**

I give consent to Room to Heal’s staff to contact me where necessary, for example to invite me to an initial assessment. I understand that Room to Heal staff will save my contact details for these purposes.

**Yes ☐ No ☐**

**5. Storing and sharing my personal information**

a) My personal information will be recorded and stored securely in paper and/or electronic files as necessary. Paper files are secured in locked filing units, and electronic files are saved in our encrypted and secure database.

b) My personal information will be shared securely, with the above mentioned people and organisations, through an encrypted email server. If Room to Heal ever thinks that it has somehow compromised my personal information, I will be notified straight away.

c) I understand that Room to Heal will not release my personal electronic data unless required by law or where there is a clear overriding public or vital interest in disclosure. However, where possible, I will be told if any disclosure is to take place.

**Yes ☐ No ☐**

**6. Duty of Care and confidentiality**

Room to Heal has a Duty of Care to its clients. There may be exceptional circumstances in which there is a significant concern of a risk of serious harm to a client or another person. In such an event it may be necessary for information to be shared outside of the Room to Heal with other professionals (e.g. a Doctor). Wherever possible, the service would seek consent of the client.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please note:***If you do not wish to grant Room to Heal consent to hold any of your personal data for the above-mentioned purposes, you are in no obligation to sign this consent form.

However, in the case you do not wish to grant us consent to process your data for the purposes of membership, referral and third party communications, you may not be able to access our full services and we may not be able to fully assist you to the best of our abilities.

You are allowed to withdraw consent from Room to Heal at any point and for any reason. To do this, you can:

* Orally express your desire to withdraw consent to any member of staff
* Or email info@roomtoheal.org
* Or call us at 07863 442929

We will ask you to sign a consent withdrawal form. We may ask if you would like to share your reasons for withdrawing consent from Room to Heal. We will dispose of all your personal data securely and permanently following your request. Please find our Privacy Notice attached.