Blackthorn Trust
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Maidstone
ME16 9AN

referrals@blackthorn.org.uk

APPLICATION FORM FOR SELF-PAY THERAPEUTIC SERVICES

Guidelines

ABOUT BLACKTHORN

The Blackthorn Trust is a long-established Health and Community Hub offering individual holistic/anthroposophical therapies and creative group activities. We support people with a range of long-term health conditions including mental health and persistent pain.

THE SELF-PAY OFFER

There are two self-pay options available:

- Individual therapy: 12-week treatment block
- Combination Programme: 12-weeks combining an individual therapy block and a creative group.

Individual therapies we offer are:

- Arts Counselling
- Biographical Counselling
- CranioSacral Therapy
- Eurythmy Movement
- Metal Colour Light Therapy
- Rhythmical Massage Therapy

Workshops/Groups we offer are:

- Breadmaking / Cooking
- Craft
- Gardening
- Mindfulness
- Plant Nursery
- Stained Glass
- Woodwork

APPLICATION PROCESS

- To apply for an individual therapy, you can either self-refer or ask your healthcare professional to refer you using this form.
- To apply for the Combination Programme, we will **only** consider referrals from healthcare professionals (e.g. GP, psychologist, social worker) using this form.

1) Complete this form.
2) Print out and send any relevant medical history documents including medication.
3) Enclose/send copies of relevant specialist letters, summaries, or investigations.
4) Enclose/send copies of any risk assessments that have been carried out.

Once we have reviewed your completed application, a member of our team will contact you to arrange your initial assessment.

Unfortunately, we are NOT able to consider applications from people who:

- are under 16 years of age.
- have a recent history (last 3 years) or current tendency to violence.
- have a history of sexual offences.
- have a current alcohol/substance misuse or addiction.

INITIAL ASSESSMENT

During your initial assessment we will ask you for your background history and discuss the options that are appropriate and available to you. We may wish to discuss your application in the wider therapy team. In this case we will aim to contact you again as soon as possible after our next team meeting to propose a plan.

AFTER YOUR INITIAL ASSESSMENT

If you agree with the proposed plan, you will receive a confirmation letter/email with payment details and appointment dates.

Please note that payment is required in advance.

Application type (please tick below)

Individual Therapies only		Combination Programme	
See page 1 for list of therapies available		*See page 1 for available therapies and activities.* *This referral must be completed by a healthcare professional*	

Applicant's details

Name	
Date of Birth	
Address	
Postcode	
Email	
Contact number(s)	

Reason for Referral

Please tick below to indicate the applicant's reason for referral and then provide more information in the box below

Anxiety		Need for meaningful activity	
Depression/Low mood		Need for re-orientation	
General well-being		Persistent pain	
Isolation/loneliness		Sleep issues	
Lacking confidence		Social anxiety	
Low self-esteem		Transition from secondary care	
Need to develop life/social skills		Other (please detail in box below)	

Applicant's health

Please tick below to indicate your current health diagnosis/condition(s) and then provide more information in the box overleaf

Mental health		**Persistent Pain**	
ADHD		Muscular Skeletal problems	
Anxiety		Fibromyalgia	
Autism		Headache/Migraine	
Bi-polar		Back Pain	
Depression		**Other conditions**	
Eating disorder		Long Covid	
OCD		ME	
Personality disorder		Sleep disorders	
PTSD		Physical and emotional trauma	
Schizophrenia		Post Concussion Syndrome	
Other (please detail in box below)		Other (please detail in box below)	

Further information

Is the applicant:

- awaiting a diagnosis/assessment? Yes ☐ No ☐ Unknown ☐
- awaiting surgery? Yes ☐ No ☐ Unknown ☐
- recovering from surgery? Yes ☐ No ☐ Unknown ☐

Please give brief further details about the applicant's surgery/diagnosis below (if applicable)

Has the applicant:

- any history of being violent/aggressive? Yes ☐ No ☐ Unknown ☐
- been a victim of abuse? Yes ☐ No ☐ Unknown ☐
- a history of drug/alcohol abuse? Yes ☐ No ☐ Unknown ☐
- a history self-harm? Yes ☐ No ☐ Unknown ☐

Applicant's ethnic origin

☐ Asian or Asian British *(includes any Asian background for example, Bangladeshi, Chinese, Indian, Pakistani)*
☐ Black, African, Black British or Caribbean *(includes any Black background)*
☐ Mixed or multiple ethnic groups *(includes any Mixed background)*
☐ White *(includes any White background)*
☐ Another ethnic group *(includes any other ethnic group, for example, Arab)*
☐ Prefer not to say

Next of Kin

Name	
Relationship to applicant	
Address	
Postcode	
Phone number	

Relevant Professionals

GP	
GP Name	
Surgery Name	
Address	
Phone number	
Care Co-ordinator/Key Worker	
Name	
Address	
Phone number	
Email	

Other support (external agencies)	
Name	
Address	
Phone number	
Email	
Other support (external agencies)	
Name	
Address	
Phone Number	
Email	
If applicable, please detail what other support has been given to the application (e.g: counselling)	

Applicant signature			
Date		Signature	

Referrer's details and signature			
Name			
Address			
Phone number			
Email			
How long have you known the applicant			
Date		Signature	

Please send this form to: referrals@blackthorn.org.uk

Please remember to include copies of relevant medical history documentation / completed risk assessments for all referrals.