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Description automatically generated with medium confidence** Blackthorn Trust  
 St Andrews Road  
 Barming  
 Maidstone  
 ME16 9AN

referrals@blackthorn.org.uk

**APPLICATION FORM FOR SELF-PAY THERAPEUTIC SERVICES**

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| **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.   Workshops/Groups we offer are:   * Breadmaking / Cooking * Craft * Gardening * Mindfulness * Plant Nursery * Stained Glass * Woodwork   Individual therapies we offer are:   * Arts Counselling * Biographical Counselling * CranioSacral Therapy * Eurythmy Movement * Metal Colour Light Therapy * Rhythmical Massage Therapy   **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 at least 48 hours in advance of apppointments.*** |

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| **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* | |

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| **Applicant’s details** | |
| Name |  |
| Date of Birth |  |
| Address |  |
| Postcode |  |
| Email |  |
| Contact number(s) |  |

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| **Reason for Referral** |
| Please tick below to indicate the applicant’s reason for referral and then provide more information in the box below |

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

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| **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) |  |
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| **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)

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**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

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| **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 |

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| **Next of Kin** | |
| Name |  |
| Relationship to applicant |  |
| Address |  |
| Postcode |  |
| Phone number |  |

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| **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) | |

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| **Applicant signature** | | | |
| Date |  | Signature |  |

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| **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**](mailto:referrals@blackthorn.org.uk)

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