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| Child or Young Person Details |
| Name: |  |
| Address: |  | D.O.B: |  |
| Postcode: |  |
| YP Phone no(s): |  |
| YP Email: |  |
| OK to contact the YP directly? | Yes [ ]  No [ ]  Comments:  |

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| Referrer Information *(if applicable)* |
| Name: |  | Agency/Relationship to CYP: |  |
| Referrer Phone No: |  |
| Referrer Email:  |  |
| Reason for Referral:*please take as much space as you need to comment on child/young person’s current situation (including home life, school engagement etc.) and what you hope they might gain from counselling* |  |
| I have been given permission by the child/young person to make this referral: | Yes [ ]  No [ ]  |
| I have been given permission by the family (if applicable) to make this referral: | Yes [ ]  No [ ]  |

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| Parent/Carer #1 Details |
| Parent/Carer Name: |  | Relationship to CYP: |  |
| Parent/Carer Phone No: |  | D.O.B: |  |
| Parent/Carer Email:  |  |

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| Parent/Carer #2 Details *(if applicable)* |
| Parent/Carer Name: |  | Relationship to CYP: |  |
| Parent/Carer Phone No: |  | D.O.B: |  |
| Parent/Carer Email:  |  |

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| Permission to Contact |
| By email: | Yes [ ]  No [ ]  | Text reminders: | Yes [ ]  No [ ]  |
| By phone: | Yes [ ]  No [ ]  | Voicemail: | Yes [ ]  No [ ]  |
| By letter: | Yes [ ]  No [ ]  | Follow-up contact: | Yes [ ]  No [ ]  |
| Comments: |  |

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| Living Situation  |
| Lives with: | [ ]  Birth parent(s) | [ ]  Kinship Carer | [ ]  Foster Carer | [ ]  Other  |
| Legal Status: | [ ]  None | [ ]  Supervision Order | [ ]  LAAC | [ ]  CP Register | [ ]  Other[ ]  Historic |
| Name(s) and DOB of siblings: |  |

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| Contacts |
|  | Name | Relationship | Phone Number | Agency/Practice | Consent to liaise |
| Emergency contact: |  |  |  |  |  |
| GP: |  |  |  |  |  |
| School: |  |  |  |  |  |
| Other professional: |  |  |  |  |  |
| Other professional: |  |  |  |  |  |
| Space for additional comments on contacts |  |

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| Allocation Information |
| Re-referral? |  Yes [ ]  No [ ]  Don’t know [ ]  |  If yes more info:  |
| Availability for sessions: |  |
| Additional Information:*Any additional supports required or gender preference etc.* |  |

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| *For Service Admin to Complete* |
| Client Code: |  | Referral Date: |  |
| [ ]  Donation-based | [ ]  Fast Track | [ ]  Schools Contract | [ ]  Free |
| Gift Aid (D-B only): | [ ]  Yes | [ ]  No | Confirmed can pay BACs: | [ ]  Yes | [ ]  No |
| Possible intervention:*(please note that not all interventions are available in each area* |  |