**REFERRAL FORM FOR COUNSELLING SERVICE (10 – 21 Years)**

**Name:**\_\_***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***  **ID:** \_\_\_\_\_\_\_\_\_\_

**Date of referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age:** \_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex:  M / F**

**Contact Tel No:**                                  Who’s?                      Leave a message?Y/N

**Mobile No:**                                    Who’s?                   Leave a message? Y/N

**Address:**            Can we write?        Y/N

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**Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **who’s email?**\_\_\_\_\_\_\_\_\_

**GP details including contact number**

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**How did they hear about the counselling service?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School /College? :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is referring (full details to be provided)?**

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If a third party they MUST have consent of young person (no referrals

to be taken without knowledge of young person)  **Can you confirm that young person is aware of referral?** Y / N

**If Under 16 Years of age, is Parent/Guardian** (or local authority if subject of a care order) **aware?**  Y/ N

If parent is not aware then we may need to seek permission or advise them of this, so please let the young person know.

 **Brief reason why counselling requested:**

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**Any issues around risk to self or others such as self harm, suicide, aggression, violence etc?**

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**Any other information you would like to provide us:**

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