|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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: | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 | |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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: | | |  | | | | | | |

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

|  |  |  |  |
| --- | --- | --- | --- |
| 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.* | |  | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *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* | | |  | | | | | | |