Service Director, Consultant Counsellor, Trauma Therapist, Safeguarding & Clinical Lead
Child, Adolescent & Adult Counselling offering Art, Play, Talking & Trauma-Informed Therapies
Registered Member BACP & Practitioner Member of APCCA

**Child/Young Person Referral Form**

|  |  |
| --- | --- |
| **Referrer Name:**  |  |
| **Job Title / Parent / Carer** |  |
| **Address** |  |
| **Tel:**  |  |
| **Email:**  |  |

**Child’s Details**

|  |  |
| --- | --- |
| **Name** |  |
| **Date of Birth** |  |
| **Address** |  |
| **Reason for Referral** |  |
| **Relevant History** |  |
| **Relevant Medical History** |  |
| **Medication** |  |
| **Are there any external agencies involved?** Please state who and contact details |  |
| **Any Known Risks?** Threatening / Challenging Behaviour, Criminal History etc... (Where possible can a risk assessment and relevant care plan please be provided) |  |

|  |  |
| --- | --- |
| **GP Name** |  |
| **GP Surgery Address** |  |
| **GP Contact Number:** |  |

|  |  |
| --- | --- |
| **Parental / carer consent for the referral:**  |  **Yes/No** (please circle / delete as appropriate)  |
| **Parent /carer name:**  |  |
| **Telephone** |  |
| **Email** |  |

|  |  |
| --- | --- |
| **Are sessions Funded by an agency/service or are you Self-Funding** |  |

**Please return completed form via email to:** ipcs@protonmail.com

