**St Leonards Childrens Counselling**

REFERRAL FORM

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Child/young person’s name:  |
| DOB:  | Age: | Gender:  |
| Main Parent/ Carers Name: |  |
| Address:  |  |
| Post Code:  |  |
| Telephone No: |  |
| Email: |  |
| Does the family know about this referral? Y / N  |
| School Attended: Year:  |
| Any other agencies involved (give contact details where possible): |
| Name of referring person & organisation:  |
| Referrer’s contact number & Email : |
| Reason for referral |
| Safeguarding Issues?(CP/LAC/etc.) |
| Current risks?(self-harm/ suicidal thoughts/risky behaviour) |
| Any further referral information (i.e. change in child behaviour/cause for concern/ support needed) |