REFERRAL FORM – CHILD AND ADOLESCENT COUNSELLING

ORGANISATION/SCHOOL REFERRAL FORM

<table>
<tr><td colspan="2">Name of Child/Adolescent:</td><td colspan="2">M/F Other:</td><td>D.O.B:

Age:</td></tr>
<tr><td colspan="2">Parent Contact Name:</td><td colspan="2">Parent Contact Number:</td><td>Client's Mobile (If 18 years or older)</td></tr>
<tr><td>Class:</td><td colspan="3">School:</td><td>Age:</td></tr>
<tr><td colspan="2">Ethnicity:</td><td colspan="3">Home Language:</td></tr>
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Background information and reasons for referral:

What are the organisations/schools hopes from therapy?	
1.	
2.	
3.	
4.	

Please give details of any other intervention this child/adolescent has received and when?

Please give details of any diagnosis (e.g. ADHD), **any medication and/or other medical problems or allergies:**

Section 2 – Clinical

Please give details of any other agencies involved with this child/adolescent:

Referred by:		**Guidance Counsellor**	**Resource Centre**	**Youth Worker**
Attendance level within school:				
Details of any exclusions, or details of any Trauma:				

Who has parental responsibility?

Are all those holding parental responsibility in agreement with therapy? **Yes** **No**

Signature of Referrer:	**Date:**

THERAPISTS CHECK LIST:

REFERRAL DATE:	**MEETING/CALL DATE:**	**PARENT ASSES. DATE:**	**Practitioner:**

Referrer SDQ or CORE-OM COMPLETED:	**Yes**	**No**	**Parent SDQ Or CORE-OM COMPLETED:**	**Yes**	**No**

Parent's *written* consent Received:	**Yes**	**No**	**Adolescent's *verbal* consent received:**	**Yes**	**No**

Please Email Completed Form to: PlayTherapyCoClare@gmail.com

Along with completed SDQ Form.