REFERRAL FORM

Name:…… DOB:…….. Age:……. Male/Female

Address (incl. postcode)……

Tel (incl. mobile):…….... Is Young Person (YP) aware of referral? Yes / No

Name of legal guardian:…… YP school email address: ……....

Address of legal guardian:……..

Gillick competent? Yes / No Disability: Yes / No ……...

Social Worker Yes / No Name: …….. Tel: ……

Are the main carer/ guardian aware of this referral? Yes / No

Can we discuss this referral with the above carer / guardian? Yes / No

Is the YP looked after by the Local Authority? Yes / No

Medications taken by the YP (if applicable): ……....

Any allergies that the School Counsellor should be aware of? Yes / No ……...

Family Doctor: …… Tel: ……

School Year/Class:……... Form Teacher:……

***Comments by Referrer*:**

1) Why have you referred this YP? **(Please be specific)**

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2) What school/other interventions has this YP had before referral to counselling? (e.g. SAP, mentoring, behaviour support etc.) What was the outcome?

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3) Has the school followed LEI Policy/Guidelines first? (e.g. Bullying, Self-harm/Suicide) Yes / No / NA **(Please outline)**

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4) Has the YP seen their GP? Yes / No / NA If **'Yes'**, what was the outcome?

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5) Any relevant information on pupil's background or life events?

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6) How is the pupil functioning in school?

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Please indicate (X) the involvement of any of the following services with this YP.

Name of Service	Past	Current	N/A	What was the outcome of their involvement?
School Nurse				
EWO				
Behaviour Support				
Ed. Psychology				
GP				
PCMHS/CAMHS				
Social Services				
Other				
Other				

RISK ASSESSMENT OF YP (This section must be completed)

Risk of Harm to **SELF?** Yes / No (If yes, what action has been taken?)

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Risk of Harm to **OTHERS?** (e.g. students, staff, family etc.) Yes / No

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What **action** has been taken/ needs to be taken?

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Referrer Details:

Name: …….. School/Agency: ……...

Address: ……. Postcode: ……...

Tel: …….. Email: ……

Job Title (incl. your relationship to this YP) ……

Signature: ……

Date of Referral: ……..