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# School Based Counselling Service

## pRIMARY Referral form

**SCHOOL:** ……………… … ………………………. **CONTACT NUMBER………………………….**

**Reason for counselling request (please tick) PLEASE TICK ONE**

**Bullying Bereavement/Family Illness Separation/Divorce**

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:…………………………….

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| ***Comments by Referrer*:**  1) Why have you referred this YP? **(Please be specific)**  ………………………………………………………………………………………………………………………….………………………………………………………………………………………………………………………….………………………………………………………………………………………………………………………….  2) What school/other interventions has this YP had before referral to counselling? (e.g. SAP, mentoring, behaviour support etc.) What was the outcome?  ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………  3) Has the school followed LEI Policy/Guidelines first? (e.g. Bullying, Self-harm/Suicide) Yes / No /NA  **(Please outline)**  ………………………………………………………………………………………………………………………….  4) Has the YP seen their GP? Yes / No / NA If **‘Yes’**, what was the outcome?  ………………………………………………………………………………………………………………………….  5) Any relevant information on pupil’s background or life events?  ………………………………………………………………………………………………………………………….………………………………………………………………………………………………………………………….  …………………………………………………………………………………………………………………………..6) How is the pupil functioning in school? |

**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 |  |  |  |  |

|  |
| --- |
| RISK ASSESSMENT OF YP (This section must be completed) Risk of Harm to **SELF?** Yes / No (If yes, what action has been taken?)  ………………………………………………………………………………………………………………………… Risk of Harm to OTHERS? (e.g. students, staff, family etc.) Yes / No …………………………………………………………………………………………………………………………. What action has been taken/ needs to be taken? …………………………………………………………………………………………………………………………. |

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**I……………………………………… give permission for my child to see the School Based Counsellor for an assessment and any subsequent sessions.**

**Parent / Carer Signature:………………………………………Date:………………………………**

**School Staff Signature:**…………………………………………… **Date:** ……………………..

**REFERRED BY (Print Name):**…………………………………… **DATE……………………..**

**PLEASE COMPLETE AND SIGN ALL SECTIONS OF THE REFERRAL FORM, OTHERWISE THIS WILL DELAY IN THE YOUNG PERSON BEING SEEN BY THE COUNSELLING SERVICE.**

**Referrals may be emailed to: -** [**schoolcounselling@caerphilly.gov.uk**](mailto:schoolcounselling@caerphilly.gov.uk)