



Children & Young Person's Counselling – Referral Form

Personal Details

Surname:	First Name:
Date of Birth:	Male / Female
Address:	
Home telephone:	Mobile:
Parent / Carer / Contact Person at home:	Address of Parent / Carer / Contact Person
Is it safe to make contact at the above address? YES / NO	If not, who should be contacted and where?

Referrer's Details

Self-referral <input type="checkbox"/>	Contact details (if different from above)	
Parent / Carer <input type="checkbox"/>	Contact details (if different from above)	
Family member <input type="checkbox"/>	Contact details (if different from above)	
Agency <input type="checkbox"/>	Name of organisation:	Contact name:
Address:	Email address:	Contact phone number:

Does the client experience any difficulties with any of the following?

Mental Health Details:	YES / NO	Alcohol Use Details:	YES / NO
Drug Use Details:	YES / NO	Behavioural Issues Details:	YES / NO
Domestic Abuse Details:	YES / NO	Other (please specify) Details:	YES / NO

Status

Urgent / Non Urgent

If urgent, please state why _____

Other Agency Involvement

Please give names and contact details of any other professional involved with this young person.

Reason for Referral

Please explain the reason for this referral, using a continuation sheet if necessary.
