

**Parent Referral Form for Child/Young Person**

**Name of child/young person being referred** …………………………………………….....

Date of birth of child/young person ………………………

School……………………………. Year Group ………...

**Name of parent/carer referring child/young person** …………………………………………………………

Parent/Carer address …………………………………………………………………...............

Contact telephone …………………………Contact email ……………………………………

Date of referral………………………………..

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| **Why is the child/young person being referred? What are your concerns?** |
| **Is any other support currently being provided? Please describe.**  **Has the child/young person previously received other therapy/support to address her/his issues? Please describe.** |
| **Does the child have any diagnosed medical or mental health conditions?**  **Is the child/young person currently taking any medication related to the above? Please give details.**  **Please give name and contact details for GP** |
| **Significant events in the life of the child (e.g. loss, bereavement, illness, care arrangements, frequent moves)** |
| **What would you like the child/young person to gain from the therapy?** |

Signature ……………………….…………………. (parent / carer)

Date………………………………………………..