Therapy Referral Form



Private & Confidential

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| Referral completed by: |  |
| Date: |  |
| Role and Agency: |  |
| Contact telephone No. |  |
| Contact email address: |  |

|  |  |
| --- | --- |
| Child’s Name: |  |
| Date of birth: |  |
| Legal Status: |  |
| Parent/Carer’s name: |  |
| Child’s address: |  |
| Parent/carer’s tel. no. |  |

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| --- | --- |
| Child’s School/Nursery: |  |
| Address: |  |
| GP Name: |  |
| Address: |  |

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| Reason for referral:  *(Please include the presenting problems, and the impact on the child and family)* |
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| Significant events in the child’s life/ family background:  *(ie: bereavement/trauma/loss/parental separation/physical illness/family history of drug misuse/domestic violence etc)* |
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| Relevant medical history and details of medication: |
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| Additional information: *(ie: previous support/interventions) please include reports where relevant* |
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| Other Agencies involved with the family/child: | | | |
| Agency | Professional involved | Email address | Nature of involvement |
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| Outcomes you hope to see as a result of this referral: |
| 1. |
| 2. |
| 3. |
| 4. |

Thank you for your time in completing this referral form with as much detail as possible, it will help us to respond quickly and appropriately.

Submission of completed referral forms must be made through Egress Switch secure email to referrals@childinmind.co.uk