**Child and Family Therapy Referral Form**

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| **Date of Referral:**  |
| **Confirm Consent has been given by client to be added to RC database: (Y/N)** |
| **Please give the details of the child this referral pertains to; or, if the referral is for the whole family, please give the details of one of the children** |
| **First Name:** | **Family name:** |
| **DOB:**  | **Age:** | **Gender:** |
| **Current Address:** | **Telephone No:****(please specify whose number it is)** |
| **Country of Origin:** | **Nationality/Ethnicity:** |
| **Refugee Council support worker (if known):** | **TO BE COMPLETED BY REFUGEE COUNCIL ONLY****Database Number:** |

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| **Family details**  |
| **Name:** | **Relationship to child:** |
| **Name:** | **Relationship to child:** |
| **Name:** | **Relationship to child:** |
| **Name:** | **Relationship to child:** |
| **Name:** | **Relationship to child:** |
| **Preferred language:****Nationality/Ethnicity (if different):** | **Interpreter required:** **[ ]  Yes** **[ ]  No****Language required:** **Preferred interpreter (if known):****Preferred gender of interpreter:****[ ]  Female** **[ ]  Male [ ] Either/Any** **[ ]  Preference not known (RC to ask client when booking assessment)**  |
| **Preferred gender of therapist:[ ]  Female [ ]  Male [ ]  Either/Any****[ ]  Preference not known (RC to ask client when booking assessment)**  |

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| **School details** |
| **Name of school:**  | **Address:**  |
| **Teacher’s name:**  |
| **Other key contacts in school:** | **Telephone No:** |

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| **GP details** | **Social Services or other support services** |
| **GP name:**  | **Name & Role:** |
| **Address:** | **Tel. No:**  |
| **Tel. No:** | **Email:** |

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| **Reason for referral** |
| **What are the family’s main concerns? What are your concerns?** |
| **What is working well in the family (e.g. identified strengths, protective factors, other relationships that have a positive impact)?** |
| **Is the family aware of the referral? Who might come to therapy?** |
| **Any risk issues:**  |

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| **Referrer’s details** |
| **Name & Role:** | **Email:** |
| **Tel. No.** | **Date:** |

Please return this form to: Therapeutic.Sheffield@refugeecouncil.org.uk