The Pilgrim School

REFERRAL FORM for THERAPEUTIC SUPPORT

CONTACT DETAILS

CLIENT DETAILS:			
Full Name:		Preferred Name & Pronouns:	
Date of Birth:		Year Group:	
Academic Link:		PSWS:	
The Pilgrim School Base:		Referral Date:	
Address (incl. Postcode):			
Contact Phone number:		Alternative Phone Number:	
Email Address:			
FSM:	YES / NO	EHCP:	YES / NO / PENDING

REFERRER DETAILS: (please complete if you are making a referral on behalf of the client named above)			
Name:		Contact Phone Number(s):	
Role:			
Email Address:			
I confirm that I have the consent of the client named above to submit this referral on their behalf.			
Signed:		Date:	

EMERGENCY/NEXT OF KIN CONTACT DETAILS:			
Name:		Relationship:	
Contact Phone Number:		Alternative Phone Number:	

GP Contact Details:	
Name:	
Address:	
Telephone Number:	

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PREFERRED THERAPEUTIC SUPPORT: (Please highlight)		
COUNSELLING	ART THERAPY	~~DRAMA THERAPY~~ (CURRENTLY UNAVAILABLE)

FURTHER INFORMATION

Briefly state reason for seeking support, including length of time concerns have been present:

How do you hope support might help?:

Availability: Please give times when you (the young person) are timetabled to be in school or include your current timetable.

Medication: Please provide details of any medication you (the young person) are currently taking and when you began taking it.

History: Please give details of any diagnosis, learning difficulties, mental health difficulties or relevant significant information. Please use additional paper as required.

Support: Please provide details of any current support you (the client) have in place (e.g. Early Help, LA Young Carer Support, Youth Offending Team) and any previous support you have had. Include here whether you have previous received therapeutic support form The Pilgrim School (i.e. ELSA, Art Therapy, counselling)

Are you (the client) currently engaged in or have you previously engaged with any talking therapy (e.g. CAMHS, private counsellor, CASY)? If so, please give details.

TO BE COMPLETED BY REFERRAL PANEL ONLY

Therapeutic Support Offered:

Allocated Therapist:

Client ID:

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A signature must be provided by the named client. By providing a signature, the client is agreeing to this information above being shared with the referral panel and a referral for counselling being made.

Signed: ________________________________ (named client)   Dated: ___________________

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Therapeutic Support Offered:
Allocated Therapist:
Client ID: