Referral Form

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| Date of Referral: |  |
| Referrer’s Name: |  |
| Organisation:  (and team if applicable) |  |
| Telephone number: |  |
| Email address: |  |
| Address: |  |
| Team Manager: |  |

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| Names of Child(ren) - Clients | DOB: | Date Placed: | Legal Status /  CP Register |
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| Contact Details of Client’s Caregiver: | | |
| Name: | Address: | Telephone number: |
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| Household structure: | | |
| Name: | Age / DOB: | Relationship to child: |
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| Significant other relatives: | DOB: | Relationship: | Level of contact: |
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(If a genogram is available, please attach).

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| Reasons for Referral:  (Please include factors contributing to referral, current behavioural issues, family dynamics) |
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| Family History relating to difficulties: (Please include dates clients were known to social services). |
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| Outline of therapeutic intervention required:  (Please specify individual clients’ needs) |
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| Are the clients aware of referral? What are their views? |
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| Are the clients currently subject to court orders or care proceedings?  (please give dates and details of granted orders or current proceedings) |
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| Previous placements/residence with other caregivers: | | |
| Caregiver name & Relationship | From | To |
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| Lone Working:  Are there any risks identified with the clients that the therapist should be aware of? |
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| Have any of the clients been suspected or convicted with sexual or violent offences? Please provide details: |
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| What are the long term plans for the child(ren)? |
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| Will the details of this intervention be included in court hearings?  (Please give details – a letter of instruction will also be required). |
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| Please outline other services involved with this family: | |  |
| Service: | Role: | Email / tel if recent: |
| e.g. ELSA – Named worker | Focus of sessions |  |
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Prior to work beginning, the following is required:

* Further discussions with the referrer to clarify, confirm and negotiate details of intervention.
* A completed Quote Form
* Confirmation of consent for intervention to be undertaken.
* Sight of all relevant reports, assessments or information which will inform the intervention. If Therapeutic Life Story Work, additional information is required.

Referrer signature: Date:

**GDPR Rules:** To comply, this information is held for the duration that the case is considered ‘open’. Following this, the personal, identifying and contact information is removed, and only clinical notes and formal reports are retained for archive. Some material may be retained, e.g. the reason for referral, if deemed appropriate.

Referral to:

(GCSx) [Laura.marie.williams@lmwplaytherapy.cjsm.net](mailto:Laura.marie.williams@lmwplaytherapy.cjsm.net)

Or [Laura@lmhchildtherapy.co.uk](mailto:Laura@lmhchildtherapy.co.uk)

Laura Marie Hanks

Play Therapist & Placement Consultant.

MSc Play Therapy

MSc Play and Therapeutic Play

BSc (hons.) Psychology and Education (BPS)

Dyadic Developmental Psychotherapy (DDP1)

For further information or a discussion about this referral, please email the above address or call 07715 673 109.

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| Office Use Only: | | |
| Date Referral Received: |  |  |
| Date of Quote Form | Work Quoted | Date signed: |
|  |  |  |
| Work Started on: |  |  |