REFERRAL FORM

Name of Chid: …… DOB: …… Male ❑ Female ❑

Address: ……

Telephone number: ……

Name of parent/legal guardian: ……

Relationship to child: ……

Year Group: …… Teacher: ……

School: …… Young Person consent sought? Yes ❑ No ❑

Gillick Competent? Yes ❑ No ❑ Parental consent sought? Yes ❑ No ❑

All referral forms MUST be accompanied with an appropriate questionnaire form:

Primary Schools (SDQ Form) Yes ❑ No ❑ Secondary Schools (YP-CORE Form) Yes ❑ No ❑

Reason for referral (tick up to three (3) appropriate :

- ❑ Abuse (Including sexual)
- ❑ Academic
- ❑ Anger
- ❑ Behaviour Related
- ❑ Bereavement
- ❑ Bullying
- ❑ Depression
- ❑ Domestic Abuse
- ❑ Eating Disorders
- ❑ Family
- ❑ Financial Concerns/Poverty
- ❑ Relationships with Teachers
- ❑ Relationship other than family or Teachers
- ❑ Self-Harm
- ❑ Self-Worth
- ❑ Sexual (inc orientation)
- ❑ Stress/Anxiety
- ❑ Substance Misuse
- ❑ Suicide
- ❑ Other

Further Information (Please use reverse if more space is needed)

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Any other services/professionals involved in child's welfare (tick as appropriate):

- ❑ EP Service
- ❑ Advisory Teacher
- ❑ Educational Welfare Service
- ❑ Behaviour Support Service
- ❑ Education Support Worker (LAC)
- ❑ Social Services
- ❑ On Child protection register: Yes/No
- ❑ Health Professionals *(please specify)*
- ❑ Other:
- ❑ Not known

STAGE OF THE CODE OF PRACTICE STATEMENTED: Yes/No

DATE OF STATEMENT:

- ❑ Cognitive/Learning
- ❑ Behaviour/Emotional/Social Dev
- ❑ Communication/Interaction
- ❑ Sensory/Physical

Referred by: …… Date: ……

❑ Parent ❑ Teacher ❑ Other (Please Specify): ……

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