

# Referral Form For Psychotherapy Young People's Project



Please complete in as much detail as possible, providing supporting reports and assessments where available

### Child details:

Surname ..... First name(s) .....  
Date of Birth ..... Gender .....

### Details of parents / carers with whom the child is *currently* living:

Name (1) ..... M / F ..... dob: .....

Relationship to child .....

Name (2) ..... M / F ..... dob: .....

Relationship to child .....

Address .....

Tel no ..... Email .....

### Details of other children with whom the child is *currently* living:

Name (1) ..... M / F ..... dob: .....

Relationship to child ..... Relationship to carers .....

Name (2) ..... M / F ..... dob: .....

Relationship to child ..... Relationship to carers .....

Name (3) ..... M / F ..... dob: .....

Relationship to child ..... Relationship to carers .....

Name (4) ..... M / F ..... dob: .....

Relationship to child ..... Relationship to carers .....

**Please provide details of any other children on the back of this page.**

**Details of birth family (if different from above)**

Mother's name .....

Address .....

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Tel no ..... Email .....

Father's name .....

Address (if different from mother's) .....

.....

.....

Tel no ..... Email .....

**Names and dates of birth of siblings**

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**Referrer details**

Name ..... Position .....

Organisation .....

Address .....

.....

.....

Tel no ..... Email .....

Is the client aware of this referral? Y / N

Are the parents / foster carers aware of this referral? Y / N

**Client support network**

Name ..... Position.....

Address .....

.....

Tel no ..... Email .....

Name ..... Position.....

Address .....

.....

Tel no ..... Email .....

Name ..... Position.....

Address .....

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Tel no ..... Email .....

Name ..... Position.....

Address .....

.....

Tel no ..... Email .....

Name ..... Position.....

Address .....

.....

Tel no ..... Email .....

Name ..... Position.....

Address .....

.....

Tel no ..... Email .....

**Ethnic Background**

Please tick the box that best describes the child's ethnic origin

- Bangladeshi .....
- Black African .....
- Black Caribbean .....
- Black Other (please specify) .....  .....
- Chinese .....
- Indian .....
- Irish .....
- Pakistani .....
- White .....
- Other (please specify) .....  .....

First Language: .....

Other means of communicating: .....

**Reason for referral**

*If the child is a victim of abuse, please provide any witness statements or records of interview or other details, including relationship to alleged perpetrator.*

**Reason for referral (continued)**

**Level of learning disability**

Please tick the relevant box

borderline .....

mild .....

moderate .....

severe .....

please tell us any other relevant information on verbal / non-verbal communication skills

.....

.....

.....

.....

**Areas of other needs**

*Please tell us about any other relevant diagnoses (eg. autism; epilepsy; downs syndrome; physical or sensory disability...)*

**Please indicate whether any of the following apply to the child**

	Current	Previous	Never	Don't know
Accommodation by voluntary Agreement with parents (S20 Children Act 1989)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subject to a Care Order (S31 Children Act 1989)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remand to LA Accommodation (S23 (1) Children and Young Person's Act 1969)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
His/her name has been placed on the Child Protection Register	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
His/her name has been placed on the Sex Offenders' Register	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other referrals to or contact with Social Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any Social Services involvement with siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The client has ceased to be looked after within the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any details including placement details (where applicable)

**Mental health**

*Are there any indications that any of the following apply to the child?*

	Yes	No	Don't Know
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxieties/phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details (eg. any other psychiatric diagnoses) .....

.....

.....

Is there any history of mental health problems or learning disability in the family?

Yes                      No

                    

Details .....

.....

.....

.....

.....

**Please indicate whether the following apply to the child at school**

	Yes	No	Don't know
Regularly absent for other reasons than truanting e.g parental decision, illness or other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bullied at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Behavioural Issues**

Does the child present with any significant patterns of behavioural difficulties?

	Yes	No	Don't Know
Inappropriate sexualised behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School refusals/non-attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suspended/excluded from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fighting/aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bullying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damage to property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cruelty to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specified conduct disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details: .....

.....

.....

	Yes	No	Don't Know
Other behavioural issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details: .....

.....

.....

**Details of Medication**

	<b>Yes</b>	<b>No</b>
Is the client taking any medication	<input type="checkbox"/>	<input type="checkbox"/>

Please give details:

**Child's History**

*Please give the history of any trauma or abuse, including details of offending history (if appropriate.)*

**Referral requirements**

RESPOND is unable to take a referral unless two areas of responsibility are clarified: support for the client(s) and financial responsibility for treatment. This form will be returned to you if this page is left unsigned.

**Support for** ..... (client name)

This section is to be signed by the person responsible for the referral of a client to RESPOND.

I agree to the following:

- The client/s is/are escorted to and from RESPOND
- The escort will remain on RESPOND premises for the duration of the client's session
- Escorts will be sensitive to the sometimes traumatic effects of psychotherapy or Risk Assessment before or after a session
- The client/s will be supported in arriving punctually for their session
- Drivers accompanying the escort and client/s will be known to the referrer, and adequate checks will have been undertaken
- No escort is allowed to enter the consulting room unless expressly invited by the therapist
- Requests for advice and/or information should be made over the telephone and/or in writing
- The escort will be over the age of 18
- The escort will not be accompanied by other clients or family members

.....  
Signature Date

.....  
Name in capitals Position

**Financial Responsibility / Contract**

A contract outlining the service to be delivered will be sent out for signing and returning before the commencement of any treatment / assessment.

Please provide below details of who this contract should be sent to:

.....  
Name in capitals Position

Funding Authority .....

Address .....

.....

..... Postcode .....

Tel ..... Fax .....

email .....

Please tell us how you heard about RESPOND .....

.....

Please return this form to:

Respond  
24 - 32 Stephenson Way  
London NW1 2HD  
admin@respond.org.uk  
fax: 020 7387 1222