|  |
| --- |
| **SCHOOL COUNSELLING REFERRAL FORM - CONFIDENTIAL** |
| **CODE** | **DOB** |
| **CHILD’S NAME** | **M / F** |
| **Living with (names)** |
| **People who offer client support:** |
| **Relationship to child** |
| **Address:**  |
| **Tel:** |
| **GP Name:****GP Contact Number:****Name of Surgery:****Known Medication:** |
| **Other Agencies/ organisations involved:*** **CAMHS**
* **Police**
* **Court Proceedings**
* **Social Care**
* **Current Counselling**
* **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 |
| **Ethnic origin of child:****Religious affiliation:** |
| **Child’s first language** |
| **Any special needs** |
| **Does the child have an EHC plan? YES / NO** |
| **Is the child “looked after” by the local authority YES / NO** |
| **Name of School**  |
| **Class/tutor group** | **Year** |

|  |
| --- |
| **SCHOOL COUNSELLING: PUPIL BACKGROUND (to be completed by school)****CONFIDENTIAL****IMPORTANT**Please do not name the child on this form, please use “he” or “she”Hand this background information to the counsellor with the referral formDo not retain this for the child’s school record. |
| **Reason(s) for Referral. Please use this space to tell us about any concerns including problems with home, education and behavioural changes.** |
| **Relevant background information (e.g. family, hospitalisation, other agency involvement)** |
| **How is child functioning in school (academically, socially, behaviourally)?** |
| **How do you hope/expect counselling to help this pupil?** |
| **How did you (referrer) hear about Relate in schools?**  |
| **Has the pupil been consulted? YES /NO****Has the pupil been given printed information about counselling? YES /NO****What is pupil’s attitude to the suggestion of counselling?** |
| **Has the parent/carer been given information about counselling? YES /NO****Parent/Carer consent signed and returned? YES /NO****Parental consent is not needed because the child is assessed as competent to agree**  |