Referral form for 5 – 17 year old

You/ your refers to parent or guardian
Client refers to child

Everything in this referral is private and confidential. Information is not shared with any external agency without your explicit consent.The only time privacy and confidentiality is broken, is when there is a risk to self or others and/or there are other safeguarding concerns. In this instance, you will be told what has been shared, who with and why.

Date of completion	
Name of child	
Date of Birth	
Child phone number (age 14+ only)	
Name of Parent/ Guardian	
Relationship to child	Mother, father, grandparent, foster parent, other – please specify
Parent/Guardian Email Address	
Parent / Guardian phone number	
Home Address of Child	
Who lives in the house with the child? *Please include the relationship to the child and ages of any other children*	
Are there any major problems within the family relationships in the household? *If yes,please provide details*	
School Name and Address	
Name of school contact person	
Name of doctor (if known) and GP surgery address and phone number	
Do you consent to Ocean Trauma Counselling contacting your GP as part of providing support/care to your family and/or child?	Yes / No
Where would the child like to have their sessions? *Highlight all that apply*	*Face to face* *Phone* *Video Call* *School* *Walk and Talk* *Clients Home*

Please email completed form to: oceantraumacounselling@gmail.com

Does the child have learning needs or low cognitive functioning? *If yes, please explain in as much detail as you can the needs of your child*	Yes / No Details:
Consent from Parent/guardian	You confirm that you have parental or guardian responsibility for the client; that there is no Child Court Order stopping you legally granting permission for that minor to have sessions with Ocean Trauma Counselling. ☐ Confirm Do you the parent/guardian consent to the therapeutic treatment ofyour child? ☐ Yes No Do you the parent/guardian consent to be contacted by the therapists throughout the process of therapeutic support? ☐ Yes ☐ No **For children aged 13+** Do you, the parent/guardian, consent for the therapist to liaise with your child outside of sessions as deemed therapeutically appropriate without your prior knowledge? *For example, sharing of resources/self-help guidance* Yes ☐ No

Main difficulties / issues for child	*Please tick/ highlight all boxes that apply* **Behavioural** ☐ Physical aggression ☐ Impulsive ☐ Pre-mediated ☐ Property damage ☐ Inattentive ☐ Verbal aggression ☐ Defiant ☐ Sexual aggression ☐ Hyperactive ☐ Social skills **Emotional** ☐ Depression/ low mood ☐ Anxious/ excessiveworrying ☐ Increased agitation ☐ Appetite changes/eatingdisorder ☐ Quick emotional fluctuations ☐ Suicidal thoughts ☐ Sleep changes ☐ Victim of abuse

Please email completed form to: oceantraumacounselling@gmail.com

	☐ Excessive changes in energy **Academic** ☐ Speech difficulties ☐ Suspension/expulsion ☐ Reading comprehension difficulties ☐ One to one support at school ☐ Reading difficulties ☐ Spelling difficulties ☐ Math difficulties ☐ Writing difficulties ☐ Overall poor educational progress **Reasoning** ☐ Poor problem solving ☐ Poor assessment of risk behaviour

Please describe in moredetail what your child has been experiencing and what you/they hope to obtain from therapeutic treatment. **To help you, please answer these questions:** *What has your child been experiencing?* *How long for?* *How does it affect their day-to-day living?* *What do you/ your child want to obtain from therapeutic support?* *Any significant life events or triggers that the child has/might have experienced?*	
Mental Health History *including other therapeutic support or pharmacological intervention*	Does your child have any mental health diagnoses? *If yes, what is the diagnosis, when was it diagnosed and by which professional?* Yes / No Details:

Please email completed form to: oceantraumacounselling@gmail.com

	Is/has your child ever had any psychiatric medication (e.g., anti-depressants, anxiolytics, anti-psychotics etc.,)? *If yes, what is the medication, what is the dosage?* Yes / No Details: Are there currently any other agencies involved with your family and/or child? ☐ None ☐ Children's social services ☐ CAMHS ☐ Youth worker ☐ School counsellor ☐ Probation ☐ Court proceedings ☐ Other. *Please specify* If other agencies are involved with your family and/or child, do you consent for Ocean Trauma Counselling to contact these agencies as necessary to provide support/care to your family and/or child? Yes ☐ No
Risk Assessment *If yes to any question, please provide details.*	Is your child currently experiencing ***suicidal*** thoughts, ideation, or behaviours? Yes / No Details: Is your child currently experiencing ***self-harming*** thoughts, ideation,or behaviours? Yes / No Details: Are you aware of your child using alcohol or illegal substances? Yes / No Details: Are there any other immediate dangers for the child? Yes / No Details:
Any other significant information	

Please email completed form to: oceantraumacounselling@gmail.com

Enter any other information you think is necessary to support your child	
Name, signed and datedby parent/guardian	Parent/guardian's full name Signed Date

Please email completed form to: oceantraumacounselling@gmail.com