# PFM Art Therapy Group: Referral form

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| **YOUNG PERSON DETAILS** |
| Legal name |  | Gender  |  |
| Chosen name |  | Pronouns |  |
| Date of birth |  | AddressPostcode |  |
| Home phone |  |
| Mobile phone |  | School/College  |  |
| Email address |  |

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| **PARENT /CARER/ GUARDIAN DETAILS***Please be aware that if the young person is under 16 years old a parent, carer or guardian will need to sign this form and agree to the youth counsellor having direct contact with the young person.* |
| Has the parent, carer or guardian been informed of this referral? * Yes
* No
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| Full name |  | AddressPostcode |  |
| Home phone |  |
| Mobile phone |  |
| Email address |  |

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| **REFERRER DETAILS** |
| Full name |  | Organisation |  |
| Role / position |  | Relationship to young person |  |
| Phone number |  |
| Email address |  |

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| How did you or the young person come to know of counselling at Pie? |
| Is the young person under the care of any other agencies? |
| Is the young person currently receiving counselling/psychotherapy elsewhere? |

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| **ETHNICITY OF YOUNG PERSON** |  |  |
| White British |  |  | Bangladeshi |  |  |
| White Irish |  |  | Chinese |  |  |
| Gypsy or Irish traveler |  |  | Other Asian |  |  |
| White Other |  |  | Black African |  |  |
| White & Caribbean |  |  | Black Caribbean |  |  |
| White & African |  |  | Black other |  |  |
| White & Asian |  |  | Arab |  |  |
| Other mixed |  |  | Other |  |  |
| Indian |  |  | Not known |  |  |
| Pakistani |  |  | Prefer not to say |  |  |
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| **GETTING TO KNOW YOU** *- Please complete this section with the young person* |
| **Are there any specific issues that bring you to counselling?** |
| **What are you hoping to get out of these sessions?** |

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| Please select any of the lived experience characteristics that apply to you  | * Criminal justice system
* Living in care
* Poverty
* Non-mainstream education
* Racism
* Domestic abuse
* Mental illness
* Substance misuse
* Homelessness
* Living with a disability
 | *Please provide details:* |
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| Are there any other circumstances that might be helpful for us to know about? |  |

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| Please select any of the following conditions that apply to you  | * Dyscalculia
* Autism or Aspergers
* ADHD
* Dyslexia
* Hearing disability or deaf
* Visual disability or blindness
* Mobility needs
* Mental health condition
* Other medical condition
 | *Please provide details:* |
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| **RISK MANAGEMENT** |
| Does the young person pose a potential risk to themselves or others? |
| * YES
* NO
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| If ‘Yes’, please provide further information: |
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| **CONFIDENTIALITY & REFERRAL AGREEMENT** |
| *The information you have given on this form will be held in electronic format and on our secure client databases. It is covered by the Data Protection Act 1998. This means that you have the right to see any information that is kept about you if you want to. We are obliged to share some basic details with commissioners and other organisations so that they can monitor our performance in delivering a service to you. We will only share information that is needed and in your interests. However, if there is a legal requirement or duty to do so, or if there is a risk of serious harm or threat to life then we will need to pass on your information without your permission.* |
| **Young Person statement of consent:** * I agree that you can hold my personal information on your database.
* I understand that someone will check with me before they share this information elsewhere.
* I understand that if there is a risk of serious harm or threat to life, my permission will not be sought.

**Parent, Carer or Guardian statement of consent:** *- required if young person is under 16 years old** I consent to this referral and to the young person having counselling
* I give permission for the youth counsellor to have direct contact with the young person.
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| **Young person’s signature** |  | **Parent, carer or guardian signature**  |  |
| **Printed name** |  | **Printed name** |  |
| **Date** |  | **Date** |  |