

Murray Hall Community Trust

Creative Therapeutic Services

The Bridge

St Marks Road

Tipton

DY4 0SL

01902 826 306/308

*Office Use Only- Date Received to CTS:*

*Client ID: ECAF No.*

|  |
| --- |
| **Criteria**  |
| **Is this child aged between 5 – 18 years?** Choose an item. |
| Mark at least one box from each line | **Connection to Sandwell:** School Address [ ]  Home Address [ ]  GP Address [ ]  |
| **Directly or indirectly affected by:** Abuse [ ]  , Domestic Abuse [ ]  , Looked After Child [ ] , Separation / Loss (*Includes Parent in/ returning from Prison*) [ ]  |
| **Child / Young Person’s Details** |
| **Full Name** | Click or tap here to enter text. |
| **Gender** | Choose an item. | **Date of Birth** | Click or tap here to enter text. | **Age** | Click or tap here to enter text. |
| **Home Address** | Click or tap here to enter text. | **Postcode** | Click or tap here to enter text. |
| **Telephone** | **Home:** Click or tap here to enter text. **Young Persons Mobile:** Click or tap here to enter text.  |
| **Main Language Spoken** |   | **Ethnicity** | Choose an item. |
| **Religion** | Click or tap here to enter text. | **ECAF no. if known** | Click or tap here to enter text. |
| **GP Name and Address** | Click or tap here to enter text. |
| **Education** |
| **School / College attended** | Click or tap here to enter text. | **Attendance** | Click or tap here to enter text. **%** |
| **School / College Address** | Click or tap here to enter text. | **Postcode** | Click or tap here to enter text. |
| **School / College Telephone** | Click or tap here to enter text. | **On SEN register?** | Choose an item. |
| **Home** |
| **If appropriate, a nominated family member will be asked to attend 2 sessions of therapy with the child/young person at the end of their one to one sessions. If the client is under 13yrs parents/ carers must be made aware of the referral.** |
| **Parent/Carer 1 Name** | Click or tap here to enter text. | **Relationship** | Click or tap here to enter text. |
| **Address** (if different from above) | Click or tap here to enter text. |
| **Telephone** | **Home:** Click or tap here to enter text. **Mobile:** Click or tap here to enter text. |
| **Is this Parent/Carer aware of this referral?** Choose an item. |
| **If not why?** Click or tap here to enter text. |
| **Parent/Carer 2 Name** | Click or tap here to enter text. | **Relationship** | Click or tap here to enter text. |
| **Address** (if different from above) | Click or tap here to enter text. |
| **Telephone** | **Home:** Click or tap here to enter text. **Mobile:** Click or tap here to enter text. |
| **Is this Parent/Carer aware of this referral?** Choose an item. |
| **If not why?** Click or tap here to enter text. |
| **Who does the child/young person live with?** |
| **Name** | **Age** | **Relationship to child/YP** | **Additional information** |
| Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |
| **Reason for referral** |
| **Referral Criteria: 1.** Choose an item. **2.** Choose an item. **3.** Choose an item. |
| **Brief background/ history** | Click or tap here to enter text. |
| **Currentarea(s) of concern** *(How is this child presenting? Concerns should be within last 6 weeks. You must evidence the requirement for therapeutic intervention)* |
| Click or tap here to enter text. |
| **Additional Details** |
| Is the child/young person currently involved with Early Help? | Choose an item. |
| Is the child/young person on a Child in Need/ Child Protection plan? | Choose an item. |
| Is the child/young person accessing CAMHS? | Choose an item. |
| Does the child/young person have any disabilities or additional needs? | Choose an item. |
| Is the child/young person on any medication? | Choose an item. |
| Are the police currently involved? | Choose an item. |
| Has the child/young person accessed counselling/therapy before? | Choose an item. |
| Have Social Services ever been involved with the child/young person? | Choose an item. |
| Has there been an attempt to self-harm in the last 3 months?  | Choose an item. |
| **If you have answered YES to any of these, please give details including dates of any interventions.** |
| Click or tap here to enter text. |
| **Please give details of any other key professionals working with the Child/Young Person** |
| **Name** | **Organisation** | **Role** | **Contact Details** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Referrer Details** |
| **Name** | Click or tap here to enter text. | **Role/Relationship to Child/YP** | Click or tap here to enter text. |
| **Organisation/Agency Name** | Click or tap here to enter text. |
| **Address** | Click or tap here to enter text. |
| **Email** | Click or tap here to enter text. |
| **Telephone:** Click or tap here to enter text. **Mobile:** Click or tap here to enter text. | **Date Submitted** | Click or tap to enter a date. |

**CONSENT**

Please note that consent is **required to process** the **referral** request. If a referral is sent via email or telephone a scanned signed consent will need to be attached. Alternatively a paper copy can be sent to the MHCT office.

***(Please use separate consent document alongside this referral)***

***Please note that without GDPR consent MHCT will not be able to accept a referral****.*