**ABERDEENSHIRE SCHOOL COUNSELLING SERVICE**

**REFERRAL FORM**

**CONFIDENTIAL**

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| **Referrer Details** | | | | | | |
| Name and designation of person making referral | Click or tap here to enter text. | | | | | |
| School Telephone and e-mail contacts | Click or tap here to enter text. | | | | | |
| Date of Referral | Click or tap here to enter text. | | | | | |
| **Contact Information** | | | | | | |
| Name of young person | | Click or tap here to enter text. | | | | |
| Stage of education & registration class | | Click or tap here to enter text. | | | | |
| Date of Birth | | Click or tap here to enter text. | | | | |
| Gender | | Click or tap here to enter text. | | | | |
| Home postcode | | Click or tap here to enter text. | | | | |
| School attendance concerns? | | Click or tap here to enter text. | | | | |
| Health issues which could impact engagement? | | Click or tap here to enter text. | | | | |
| Preferred appointment times/ times to avoid – please attach timetable (Secondary pupils) | | Click or tap here to enter text. | | | | |
| Pupil’s email address  (For pupils over age 12) | | Click or tap here to enter text. | | | | |
| Pupil’s telephone number  (For pupils over age 12) | | Click or tap here to enter text. | | | | |
| Class Teacher (Primary)/  Guidance Teacher (Secondary) | | Click or tap here to enter text. | | | | |
| House | | Click or tap here to enter text. | | | | |
| Named Person | | Click or tap here to enter text. | | | | |
| Lead Professional (if relevant) | | Click or tap here to enter text. | | | | |
| **About the Young Person** | | | | | | |
| - Are they on the Child Protection Register? | | | | | Please Tick:  Yes  No | |
| If yes, please give brief details  Click or tap here to enter text. | | | | | | |
| - Who do they live with? | | | | | Please Tick:  mother / father  foster care   kinship carer  adoptive parent  hostel / living independently   other | |
| If other, please specify  Click or tap here to enter text. | | | | | | |
| - Do they have other additional support needs? | | | | | Please Tick:  Yes  No | |
| If yes, please specify, or if there is a Pen Portrait of the needs and strategies / supports that work for this young person please attach to the referral  Click or tap here to enter text. | | | | | | |
| - Do they carry an epi pen? | | | | Please Tick:  Yes  No | | |
| If yes, please provide instructions for use  Click or tap here to enter text. | | | | | | |
| **Consultation for Referral** | | | | | | |
| Has this young person’s parent/carer been consulted and given permission for the referral to be made?  (For 10-11 year olds written parental consent is required) | | | | | | Yes  No |
| Has the young person been consulted about the referral and indicated they are happy for it to be submitted? | | | | | | Yes  No |
| In consultation with this young person, have they indicated they would be comfortable accessing counselling online? | | | | | | Yes  No |
| **FOR PRIMARY SCHOOLS ONLY**  Would a parent / carer be able to transport the young person to the Secondary School or Enhanced Provision Primary School to access counselling? | | | | | | Yes  No |
| **Please note, if a young person cannot access counselling on-line or be transported, counselling will be provided at their designated school.** | | | | | | |
| When discussing the referral with the parent, was there anything the parent wanted the counsellor to be aware of?  Click or tap here to enter text. | | | | | | |
| **Nature of Wellbeing Concern** | | | | | | |
| What are the reasons for the referral?  Anxiety  Attachment  Bereavement  Emotional regulation  Interpersonal Skills | | | Negative Coping Strategies  Peer Group Difficulties  Personal/Family circumstances  Sexual & Gender Identity  Other | | | |
| Brief summary, including any observations, behaviours or things a young person has said:  Click or tap here to enter text. | | | | | | |
| To your knowledge, has this child/ young person been affected by adverse childhood experiences? | | | | | | |
| Domestic Violence  Emotional abuse  Parental drug/alcohol difficulties  Loss of a parent  Physical abuse  Parental Separation/divorce  Sexual abuse  Neglect  A member of household in prison  Parent with mental health condition | | | | | | |
| Does the young person have a multi-agency Child’s Plan**?**  Yes No  In process | | | | | | | |
| Please indicate services currently in place to support the young person: | | | | | | | |
| School Nurse | | | | Children’s Panel | | | |
| CAMHS  Educational Psychologist  Intervention and Prevention Teacher  Pupil Support Worker | | | | Social Work  Family Support Worker  Crisis Intervention Worker | | | |
| If relevant/known, what was covered (e.g. psychoeducation, managing anxiety etc.)?  Click or tap here to enter text. | | | | | | | |
| When discussing the referral, what did the young person feel they wanted to get out of counselling? (it may be helpful to go through the counselling leaflet with the young person)  Click or tap here to enter text. | | | | | | |

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| **For School Counsellor:** |
| **Date Referral Reviewed:** Click or tap here to enter text.  **Accepted? YES**  **NO**  **If declined, please give reasons:**    Click or tap here to enter text.  NB It is the responsibility of the DHT Pupil Support to share the outcome of the referral with the Named Person. |

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| Date received by counsellor | Click or tap here to enter text. |