**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 detailsClick 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 specifyClick or tap here to enter text. |
| - Do they have other additional support needs? | Please Tick: Yes [ ]  No [ ]  |
| If yes, please list what these are and if the young person has any formal diagnosis please specify. (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 useClick 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 [ ]  |
| Please confirm this young person understands what counselling is and is making an informed choice to attend counselling sessions? |  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  |
| Please provide detail of ACEs as appropriate:Click or tap here to enter text. |
| 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.**Undertaken further consultation with referrer (if needed)? YES [ ]  NO [ ]** **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. |