**Creative Therapy Referral Form – Individual Sessions**

**Section A** to be completed by Education Provider

|  |  |  |  |
| --- | --- | --- | --- |
| Contact details of staff member making the referral | Pupil’s name and address | School | Year Group |
| Phone:Email: |  |  |  |
| Special Educational Needs(e.g Education and Health Care Plan) | Has this pupil been discussed at Frome Learning Partnership Behaviour Panel? (If yes please provide date) | Is there agency involvement or a safeguarding plan in place? | Designated Safeguarding Lead |
|  |  |  | Phone:Email: |

|  |
| --- |
| In as much detail as you can please describe why you have referred this young person for therapy. Please include any significant life events. |
| Desired outcomes on completion of therapy: |

Please include any essential information from the following documents and any others that you feel may be relevant:

EHCP, IEP and Positive Behaviour Plan, Last School Report, Annual Review, CAMHS involvement.

**Creative Therapy Referral Form – Individual Sessions**

**Section B** to be completed by Parent/Guardian

PARENT/GUARDIAN CONSENT FORM

Please ensure all sections are fully completed (in ink)

DETAILS OF YOUNG PERSON:

FORENAME..........…….......................... SURNAME...............................................

KNOWN AS……………………………………………………

DATE OF BIRTH ....................…….........

HOME ADDRESS …………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………

POST CODE ………………………………… HOME TELEPHONE NUMBER…………………..

PARENT/GUARDIAN

NAME & FULL ADDRESS:……………………………………………….………….

……………………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………

CONSENT FORM

I give permission for ………………… to have individual weekly creative therapy sessions at Critchill School. I understand that these sessions take place for 50 minutes on a one-to-one basis. I understand that we can withdraw from this arrangement at any time, with appropriate notice.

Signed:

Print: Date:

Please use the space provided to share any additional information you feel may be relevant:

…………………………………………………………………………………………………………………………………………………………………………………………………………………………

PARENT/GUARDIAN FORM (cont.)

EMERGENCY CONTACT DETAILS

Person 1 Person 2

|  |  |
| --- | --- |
| Name: | Name: |
| Telephone number: | Telephone number: |
| Relationship: | Relationship: |
| First Language: | First Language: |
| Other Language(s): | Other Language(s): |

MEDICAL INFORMATION

|  |  |
| --- | --- |
| Child’s Doctors name |  |
| Doctors address |  |
| Doctors telephone number |  |

PLEASE GIVE DETAILS OF ANY MEDICAL CONDITION OR SPECIAL CIRCUMSTANCES THAT YOU FEEL WE SHOULD BE AWARE OF:(Asthma, Allergies, impairments, etc)

|  |
| --- |
|  |

**Creative Therapy Referral Form – Individual Sessions**

**Section C** to be completed by Young Person

Have you had therapy or counselling sessions before? If so, what was/was not helpful?

|  |
| --- |
|  |

What would you like to get out of Creative Therapy?

|  |
| --- |
|  |

**Please fill the following section out if you are aged 11 or above.**

These questions are about how you’ve been feeling over the last week. Please read each question carefully. This is so that we can understand more about your mental health and wellbeing.