

NAOS Partnership and Community Agencies Referral Form

 Please return securely to your Project Lead or to info@naos.org.uk

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| Name of person raising referralContact number for referrerEmail Contact for referrer |  |
| Role of person referringName of Agency referring  |  |
| Date of Referral  |  |
| Has this referral been discussed with the young person and how do they feel about it? |  |
| Has parental / carer consent been obtained if required?Please confirm details  |  |
| If Social Services are working with this young person have they agreed to therapy?Please confirm the name and contact details for the Clients Social worker  |  |

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| Clients Name |  |  |
| Clients Date of Birth  |  |  |
| Client’s addressPostcode |  |  |
| How does the client Self Identify? in terms of gender |  |  |
| How does the client Self Identify? in terms of ethnicity  |  |  |
| Client’s telephone number or parental contact number  |  |  |
| Clients email address |  |  |
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| Primary carer’s name & phone number IF UNDER 18 |  |
| EMERGENCY CONTACT NUMBERWho should we contact in the first instance |  |

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| G.P. name & contact details |  |
| Medication  |  |
| Any Medical Conditions |  |
| Drug and or Alcohol usePast & Present |  |

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| Is the client currently involved with a Psychiatrist / Psychologist Counsellor or Psychotherapist?If yes, please give details. |  |
| Has the client had previous experiences with Therapy?If yes, please give details. |  |

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| Reason for referral *(please include as much detail as possible i.e. disclosure, inappropriate behaviour, outward distress, any views of the young person and/or carer)* …… *continue on the back of this form* |
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| Involvement with any statutory and or voluntary agencies – please include length of involvement and frequencyInclude contact details where known  |
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| Please confirm the details of any discussions that informed your referral to NAOS for mid- term Therapy (12-24weeks) e.g.; recommendation, GP, Mental health team suggested, Internal Triage, Onward Therapy referral, EHCP  |
| Please attach any supporting documents that you feel may be useful .......... |

**For use by Allocation Team:**

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| Date referral discussed by the team | Name of Therapist allocated to: | Any comments: |
| Date of Initial meeting with Young Person |  |  |
| Commencement of Counselling/Therapy / Group workDate: |  |  |
| End date: |  |  |