

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 referral  Contact number for referrer  Email Contact for referrer |  |
| Role of person referring  Name 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 address  Postcode |  | |  |
| 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 |  |  | |
|  |  |  | |
| Primary carer’s name & phone number IF UNDER 18 |  | | |
| EMERGENCY CONTACT NUMBER  Who should we contact in the first instance |  | | |

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| G.P. name & contact details |  |
| Medication |  |
| Any Medical Conditions |  |
| Drug and or Alcohol use  Past & 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 frequency  Include 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 work  Date: |  |  |
| End date: |  |  |