**Client ref no (office use only) ……………………………**

****121 Youth Counselling

Managed by: Hart Voluntary Action

Civic Offices

Harlington Way

Fleet

Hampshire

GU51 4AE

**Referral Form**

We accept referrals from young people, their parents (or guardians), school, GPs or CAMHS. Please complete the form below and either email to [121@hartvolaction.org.uk](mailto:121@hartvolaction.org.uk) or post to the address above marked Confidential FAO Counselling Services Manager. If you would prefer to talk to someone then please call 01252 815652 and we can complete the form for you.

|  |  |
| --- | --- |
| **Date of referral:** |  |

**Referrer Details (if young person is not referring themselves):**

|  |  |
| --- | --- |
| **Name of Referrer:** |  |
| **Email Address of Referrer:** |  |
| **Mobile Number of Referrer:** |  |

**Details of Young Person:**

|  |  |
| --- | --- |
| **Name of Young Person:** |  |
| **Date of Birth:** |  |
| **Gender:** |  |
| **Ethnic Identity:** |  |
| **Address:** |  |
| **Mobile Number:** |  |
| **Email Address:** |  |
| **Is the young person aware of the referral?** | **Yes/No (please delete as appropriate)** |
| **Are the parents aware of the referral?** | **Yes/No (please delete as appropriate)** |

**Main point of contact for Young Person (this is the information we will use to contact you to arrange sessions):**

|  |  |
| --- | --- |
| **Name of contact:** |  |
| **Phone Number of contact:** |  |
| **Email Address of contact:** |  |
| **Preferred Method of Contact:** | **Phone/email/post (please delete as appropriate)** |

|  |  |
| --- | --- |
| **Where did you hear about 121 Youth Counselling?** |  |

**Details of GP:**

|  |  |
| --- | --- |
| **GP Name:** |  |
| **GP Address:** |  |
| **Is the GP aware of this referral?** | **Yes/No (please delete as appropriate)** |
| **Is CAMHS aware of this referral?** | **Yes/No (please delete as appropriate)** |

**Education Details (if applicable):**

|  |  |
| --- | --- |
| **Which School, College or University do you attend?** |  |
| **Are they aware of your referral?** | **Yes/No (please delete as appropriate)** |

**Availability:** (We offer Counselling from a variety of locations across Hart. Currently these are Odiham, Fleet, Yateley and Hook. Counselling sessions run from 15.30 up until 21.00 Monday to Friday)

|  |  |
| --- | --- |
| **Please detail here when you would be available:** |  |

**Previous experience of Counselling:**

|  |  |
| --- | --- |
| **Has the young person had any previous experience of Counselling?** | **Yes/No (please delete as appropriate)** |
| if yes please give details: |

**Reason for referral:**

|  |  |
| --- | --- |
| **Presenting Issues (please provide us with a brief outline of why the young person would like to receive Counselling):** | |
|  | |
| **Is the young person feeling suicidal?** | **Yes/No (please delete as appropriate)** |
| **Does the young person have an eating disorder?** | **Yes/No (please delete as appropriate)** |
| **Is there any history of self harm?** | **Yes/No (please delete as appropriate)** |

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