Agency Referral Form
Therapeutic Service

Following receipt of the completed referral form, an Assessment will be required for the therapeutic team to ascertain whether therapeutic intervention is suitable for the family being referred. If so they will complete an evaluation parent and child meeting and we will allocate the individual with the appropriate service from the list below:

For Cottage staff use only:

- Children/Young People Therapeutic Play
- Family Focus
- Creative Therapeutic Group
- Adult Counselling

For a referral to be considered onto the service, the family being referred must live in the *Kirkcaldy/Dysart* catchment area and the young person must be *5-16 years of age*.
Please provide as much detailed information about the family as possible.

Adult/child/young person's details:

First name		Address line 1	
Known as		Address line 2	
Surname		Town/city	
Gender		Postcode	
Date of birth		Phone number	
Email address			

Parent/carer contact details *(applicable for child/young person*):

Details	**Parent/carer 1**	**Parent /carer 2**
First name		
Surname		
Address (if different to child/young person		
Relationship to child/young person		
Phone number		
Email address		
Please indicate any ethnicity/social/ cultural/religious beliefs.		

Criteria for Service	**Yes**	**No**
Are any of the children within the family placed on the child protection register or looked after?	☐	☐
Has there been a relationship breakdown?	☐	☐
Has behavioural issues been identified?	☐	☐
Has mental health issues been identified?	☐	☐
Has substance abuse been identified?	☐	☐
Has physical/emotional/sexual abuse been identified?	☐	☐

Consent:

Who has given consent for this referral?		
Has consent been given to share information with other agencies?	Yes ☐	No ☐
Who have you consulted prior to this referral?		

Please describe the Adult/child/young person's living arrangements, and any formal care:

Please give details of everyone in the home:

Name	Date of Birth	Relationship to the child/young person *(if applicable)*	
Legal Status: Who has parental rights and responsibility?			
Any other people in the home:		Yes ☐	No ☐

Please give any details of Child protection issues, past or present:

Do you have any of the following safety concerns about the Adult/child/young person?
(Please complete all sections)

Suicidal thoughts - Y/N	Please give details:
Risk of harm to self - Y/N	Please give details:
Risk of harm to others - Y/N	Please give details:
Other safety issues - Y/N	Please give details:

Please describe the reason for referral, including:

- How severe the difficulties are
- When they started
- How often they occur
- How they impact day to day life
- Any variance across settings (e.g. home, school)

Please give details of services previously/currently accessed regarding the adult/child/young person's emotional wellbeing:

Service	Intervention	Outcome	Date

Please give details of any relevant past or present issues relating to:

a. General health and any medical history including assessments, diagnosis, interventions and/or specific difficulties or disabilities	
b. Concerns about developmental issues and progress at nursery/*school (e.g. developmental delay, specific language impairment, learning difficulty/disability)* c. Significant life *events (e.g. loss, trauma, bereavement)*	
d. Any other factors impacting on the Adult/child/young person's wellbeing	

What are your expectations of the individual following this referral regarding the following?

Aims	
Concerns	
Outcomes	

Referrer's details: **GP's details**

Full name		Full name	
Job title		Practice name	
Organisation		Address	
Address		Phone number	
Phone number		Email address	
Email address			

Details of Professionals currently involved with the Adult/child/young person:

Named person		**Lead professional (if applicable)**	
Full name		Full name	
Job title		Job title	
Organisation		Organisation	
Address		Address	
Phone number		Phone number	
Email address		Email address	

Education ***(applicable for child/young person)***	
Name of nursery/school/college	
Full name of main contact/guidance teacher	
Phone number	
Email address	

Other Service/Professionals		**Other Service/Professionals**	
Full name		Full name	
Job title		Job title	
Organisation		Organisation	
Phone number		Phone number	
Email address		Email address	

Please give details of any support needs/arrangements required to meet with the Adult/child/young person and their family (e.g. interpreter)

Is there any other relevant information?

Emergency contact details:

First name		Address line 1	
Known as		Address line 2	
Surname		Town/city	
Gender		Postcode	
Date of birth		Phone number	
Email address			

Data Protection and GDPR declaration:

In accordance with the Data Protection Act and General Data Protection Regulation, we require your signature to authorise us to hold any information about families being referred by you, particularly for any period of time. All information held is confidential and is shredded when it is no longer required.

Date form completed:	

Referrer Signature:	

Please email your completed Referral form to: administration@thecottagefamilycentre.org.uk

For Cottage staff use only:

Art/Play Therapy – ☐

Therapeutic Group - ☐

Family Focus – ☐

Connecting Families – ☐

Adult Counselling – ☐