**COUNSELLING REFERRAL FORM**

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| **Young Person Details:** | | | | | | | | |
| First name |  | | Surname | |  | | | |
| Prefer to be known as |  | | Date of Birth | |  | | Age |  |
| Address  (where the young person is living now) |  | | Postcode | |  | | | |
| \*Contact number(s) | |  | | | |
| \*Email | |  | | | |
| Gender |  | | Ethnicity | |  | | | |
| GP / Surgery |  | | GP address and contact number | |  | | | |
| School |  | | School keyworker | |  | | | |
| First Language |  | Interpreter required: | Yes/No | If yes, which language: | |  | | |

\*Please only give contact details where consent is given for us to use these to make contact.

|  |  |
| --- | --- |
| **Parent/Carer’s details:** | |
| Name |  |
| Address (if different from above) |  |
| \*Contact number(s) |  |
| \*Email |  |
| Other significant carers/family members |  |

\*Please only give contact details where consent is given for us to use these to make contact.

PTO

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| **Reasons for Referral:** |
| Please give a brief description of the main current difficulties/challenges, including health problems/diagnosis |
|  |
| Any relevant background information/significant life events/recent changes? |
|  |
| Any concerns about risk or safeguarding that you would like us to know about? |
|  |

Please email the completed form to [referral@flynnesbarn.org](mailto:referral@flynnesbarn.org)

or

Send to **Flynne’s Barn, Thorneythwaite Farm, Borrowdale, Keswick, CA12 5XQ**

or

Phone us on **01768 800 686** to make the referral over the phone.

Thank you