**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.

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| **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 |
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| 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

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