

**Teenage Girls Counselling Service (13 – 18 years)**

**Professional/3rd Party Referral Form**

|  |  |
| --- | --- |
| **Referees Details** | |
| Date |  |
| Full Name |  |
| Organisation/Role |  |
| Contact Number |  |
| Email |  |
| Have you received permission from the referred person to send this form? **Yes** ☐ **No** ☐ | |

Reason for referral:

Any other Agency Involvement? Please give details & Contact No:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Young Persons Details** | | | | | |
| Full Name |  | | | | |
| Address |  | | | | |
| Postcode |  | | | | |
| Date of Birth (DOB) |  | Age |  | School Year |  |
| Name of School or College (if applicable) |  | | | | |
| Contact Number | Mobile: Landline: | | | | |
| Email Address |  | | | | |
| Ethnicity |  | | | | |
| GP Surgery |  | | | | |
| Disability/Additional Needs (If yes, please provide details). |  | | | | |

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| --- | --- |
| **Parent/Carers details** | |
| Full Name |  |
| Address |  |
| Contact Number |  |
| Email |  |
| **Is the young person happy for this referral information to be shared with parent/carer?**  **Yes No Please circle.** | |