

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

**Professional/3rd Party Referral Form**

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| **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:

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| **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.** |