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| CREATIVE THERAPIES & PARENTING SERVICES REFERRAL FORM | | | |
| *(Please click/tap the appropriate box)*  If you are seeking **post-SGO or post-adoption support**, please email the form to [**Adoptionsupportgateway@coram.org.uk**](mailto:Adoptionsupportgateway@coram.org.uk)  For all **other referrals including Camden schools**, please email the form to: [**creativetherapyadmin@coram.org.uk**](mailto:creativetherapyadmin@coram.org.uk)  *Please note that all* ***incomplete*** *forms will be* ***returned*** | | | |
| ***CHILD/YOUNG PERSON’S DETAILS*** | | | |
| Name: | **Date of Birth:** Type or click to enter a date | | **Current Age:** |
| **Gender:** Click or tap to enter a gender | **Ethnicity:** Click or tap to choose an ethnicity | | |
| **Nursery/School/College:** | **Year Group:** Click or tap to choose a year group | | |
| ***FAMILY DETAILS*** | | | |
| **Parent/ Carer 1:**  **Telephone & Email Address:** | **Relationship to child:**  **Ethnicity:** Click or tap to choose an ethnicity | | |
| **Parent/Carer 2:**  **Telephone & Email Address:** | **Relationship to child:**  **Ethnicity:** Click or tap to choose an ethnicity | | |
| **Address:**  **Local Authority:** | **Language(s) spoken at home** *(please state if a translator is required)* | | |
| **Other family members (names and ages):** | | | |
| ***REFERRER’S DETAILS*** | | | |
| **Name:** | **Role & setting (e.g., school/agency):** | | |
| **Telephone Number(s):** | **Email Address:** | | |
| ***OTHER PROFESSIONALS INVOLVED IN YOUNG PERSON’S WELFARE*** | | | |
| **Lead Professional:** | **Telephone & Email Address:** | | |
| **Social Worker:** | **Telephone & Email Address:** | | |
| **GP:** | **Telephone & Email Address:** | | |
| **Other:** | **Telephone & Email Address:** | | |
| ***CHILD/YOUNG PERSON’S HISTORY/BACKGROUND*** | | | |
| **Is the child/young person a Child in Need?** Click or tap to choose Y/N | | | |
| **Does the child/young person have a Child Protection plan?** Click or tap to choose Y/N | | | |
| **Has the child/young person ever had a Child Protection Plan?** Click or tap to choose Y/N | | | |
| **Does the child/young person have a CAF?** Click or tap to choose Y/N | | | |
| ***SGO/ADOPTION ONLY***  *\*Please complete the following section if seeking Post-SGO or Post-adoption support, if not, please leave blank\** | | | |
| **If post-adoption/SGO support, is the child Placed/ Adopted:** Click or tap to choose Y/N  **Adoption placement date (if not known exactly, please estimate month and year):** Click or tap to enter a date  **Date of adoption order:** Click or tap to enter a date  **How long has the child lived with the adopters?**  **Are the birth parents still involved?** Click or tap to choose Y/N | | | |
| **Please describe the Parent’s/Parents’ journey to adoption/special guardianship:** | | | |
| **Please give details about the child’s background including social context and family history (e.g., traumatic events, recent births/deaths, loss, transitions, parent’s journey to adoption, discrimination):** | | | |
| ***CAMDEN SCHOOLS ELIGIBILITY CHECKLIST ONLY:***  *\*Please complete the* *following section if the child/YP lives in or is educated in Camden, if not, please leave blank\** | | | |
| **Previous or current psychological therapy for this child/YP e.g., CAMHS (Please give details):** | | | |
| **If talking therapies have been offered & the child/YP has not been able to make use of these please explain why:** | | | |
| **Can the child/YP get to Coram accompanied by a Parent/School staff? (If No please give details):**  Click or tap to choose Y/N | | | |
| ***REASON FOR REFERRAL*** | | | |
| **Please give details for the reason for referral:** | | | |
| ***PREVIOUS EXPERIENCES OF SUPPORT*** | | | |
| **Has the child/family previously been referred to other interventions?** (e.g., CAMHS, psychotherapy, Family, speech, or occupational therapy)  **Please state the name of the provider(s) and outcome:** | | | |
| **Level of Concern** *(Click/tap)*  **Low 1**  **2**  **3**  **4**  **5**  **6**  **7**  **8**  **9**  **10**  **High** | | | |
| **Identified Risks: (Any known risks with child/parent e.g., behaviour/conduct/background)** | | | |
| **What change do you hope to bring about by a referral to Creative Therapies and Parenting Service?** | | | |
| **Can you please confirm that the Parent/Carer has provided their consent for the information provided in this form to be used for evaluation purposes?** Click or tap to choose Y/N | | | |
| Parent/Carer’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: Type or click to enter a date | | Referrer’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: Type or click to enter a date | |