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| ***CONSENT (Please complete fully)*** |
| ***Parent/Carer Consent*** |
| *Have you gained consent from the parent or carer regarding this referral?*  | *0* *Yes, they agree**0* *No, I have not asked them* |
| *Does the parent or carer consent to YESS storing their data? (a copy of our privacy policy is on our website or can be requested by email to hello@yess.uk)* | *YES NO* |
| *Does the parent or carer consent to YESS contacting them for marketing & Development purposes? (THIS CONSENT CAN BE WITHDRAWN AT ANYTIME)* | *YES NO* |
| *IF YES, HOW WOULD THE PARENT/CARER LIKE US TO CONTACT THEM?* | *PHONE EMAIL* |
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| ***CONSENT (Please complete fully)*** |
| ***Young Person Consent (if over the age of 14 years and/or Frazer Competency, Young Person can consent to referral themselves)*** |
| *Have you gained consent from the young person, regarding this referral?* | *0* *Yes, they agree**0* *No, I have not asked them* |
| *Does the child/young person have Frazer competency?* | *YES NO* |
| *Does the young person consent to YESS contacting the parent/carer (if needed) regarding this referral and ongoing therapy?* | *0* *Yes, they agree**0* *No* *0 I have not asked them* |
| *Does the young person consent to YESS storing their data? (a copy of our privacy policy is on our website or can be requested by email to hello@yess.uk)* | *YES NO* |
| *Does the young person consent to YESS contacting them for marketing & Development purposes? (THIS CONSENT CAN BE WITHDRAWN AT ANYTIME)* | *YES NO* |
| *IF YES, HOW WOULD THE YOUNG PERSON LIKE US TO CONTACT THEM?* | *PHONE EMAIL* |
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**CLIENT DETAILS (please complete as fully as possible)**

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| **Name:**   **DOB:** **Age:**  **Gender:** **Gender Identity:** **Preferred Pronouns:**  **Ethnicity:**  **GP Surgery:****School/College:**   | **Address:**     **Contact to arrange appointments:****Name:****Contact Telephone Number:****Relationship to Child or Young Person:** |

**PLEASE COMPLETE BOTH PARENT DETAILS IF SEPARATED AND PARENTAL RESPONSIBILITY IS GIVEN TO BOTH**

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| --- | --- | --- |
| **Parent/Carer Name:** | **Relationship** |  |
|  |
| **Tel** |  | **Mob** |  | **E-mail** |  |
| **Parent/Carer Name:**  | **Relationship** |  |
| Address (if different from above) |
| **Tel** |  | **Mob** |  | **E-mail** |  |

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| **C&YP Referrals only** | **Yes** | **No** | **Details**  |
| Are there current safeguarding concerns? |  |  |  |
| Please indicate first language  |  |  |  |
| Is there a physical, sensory or learning disability? |  |  |  |
| Are there issues relating to ethnicity or culture? |  |  |  |
| Are there issues relating to gender or sexuality? |  |  |  |
| Other: Please indicate |  |  |  |
| Other professionals involved with family |  |  |  |

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| **Please provide a reason for the referral, please also provide an overview of any difficulties and any areas of risk, (such as self-harm or suicide ideation):****FUNDING (Please Indicate)**SERVICE LEVEL AGREEMENT (SLA) SPOT PROVISION (NOT SLA) |

**MAIN ISSUES – Please tick all that apply**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Self Harm |  | Family Breakdown/Relationship |  | Tics |
|  | Anxiety |  | Neglect or Abuse |  | ADHD |
|  | Low Mood |  | Behavioural |  | Attachment Difficulties  |
|  | Suicidal Thoughts |  | Domestic Violence |  | Substance Misuse |
|  | Loss or Bereavement |  | Issues Around Sexuality |  | Addiction |
|  | Bullying |  | Pregnancy or Related Issues |  | Eating Disorders |
|  | Illness of Self |  | Relationships |  | Phobias |
|  | Illness of Others |  | Self Esteem |  | OCD |
|  | Anger |  | Sleep Problems |  | Other (please specify) |
|  | School Issues/ Refusal |  | Autistic Spectrum Disorder  |

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| **Referrer’s Name** |  | **Position** |  |
| Agency  |  |
| Address |  |
| Contact Tel No |  | Email |  |
| Signed |  | Date |  |