**The AOC Family Therapy Referral Form**

To Complete this referral form you MUST be 18+ years old.

**If you are a member of and related to this family complete A. If you are NOT related to this family complete B.**

**A** Are you a member of this family completing this form? Yes No

If yes, do you have permission to fill out this form? Yes No

If yes, does the family know they are being referred? Yes No

**Now complete sections C & D.**

**B**  Are you NOT a member of this family and completing this form on their behalf?

 Yes No

If yes, do you have permission to fill out this form? Yes No

If yes, does the family know they are being referred? Yes No

**If you are filling out this referral form on behalf of a family, please provide your details on page 7. Now complete sections C & D.**

**Please List Below All Family Members Who Wish to Receive Counselling/Therapy (up to six members)**

|  |
| --- |
| **Section C:****1.****Full Name:** |
| **Male Female**  | **Date of Birth:** | **Age:** |
|  **Parent Child**  | **School: (if appropriate)** |
| **2.****Full Name:** |
| **Male Female**  | **Date of Birth:** | **Age:** |
|  **Parent Child**  | **School: (if appropriate)** |
| **3.****Full Name:** |
| **Male Female**  | **Date of Birth:** | **Age:** |
|  **Parent Child**  |  |
| **4.****Full Name:** |
| **Male Female**  | **Date of Birth:** | **Age:** |
|  **Parent Child**  | **School: (if appropriate)** |
| **5.****Full Name:** |
| **Male Female**  | **Date of Birth:** | **Age:** |
|  **Parent Child**  | **School: (if appropriate)** |
| **6.****Full Name:** |
| **Male Female**  | **Date of Birth:** | **Age:** |
|  **Parent Child**  | **School: (if appropriate)** |
|  **Main Family Address (Please include Post Code)** |

|  |  |
| --- | --- |
| **Home Number:** | **Mobile Number:** |
| **Have they consented? YES  NO**  |
| **Preferred method of contact: Phone  Email  Post** **Email address:** |
| **Preferred location/venue for therapy sessions:****The AOC  Local School/Community Centre  Other**  |
| **Ethnicity** |  **African** |  **Asian** |  **Bangladeshi** |  **White/Black Caribbean** |
|  **White** |  **Pakistani** |  **Caribbean** |  **Any other Asian** |  **White/Asian** |
|  **Irish** |  **Jewish** |  **Gypsy/Roma** |  **Any Other Mixed** |  **White/Black African** |
|  **British** |  **Chinese** |  **Indian** |  **Any Other Black** |  **Other Ethnicity** |
| **Main Language Spoken by family:** |
| **Ecaf Number/s:**  |
| **Are any children on a SEN register?  Yes  No****Details:****Does any family member live with a disability? Brief description:** |
| **Does any family member receive psychiatric support? Please provide brief description:** |
|  |

**Schools / Colleges Currently Attended:**

**Family GP Name / Address / Contact Number:**

**Do any of the clients have a disability? Yes  No **

**If Yes, details:**

**Has the client(s) been referred to CAMHS or accessing CAMHS:**

**Yes  No **

**If Yes, details:**

**Are any of the clients on any medication? Yes  No **

**If Yes, details:**

**Are Social Care and Health involved with any of the clients? Yes  No **

**If Yes, details:**

**Are there or has there been any child protection issues with any clients?**

**Yes  No **

**Is the client on a Child Protection Plan?**

**Yes  No **

**Has the case been referred to the Police? Yes  No **

**Do any of the clients have any medical conditions? Yes  No **

**If Yes, details:**

**Is the case open or closed after Court Case / Police Investigation:**

**Open  Closed **

|  |
| --- |
| **Are there any family members awaiting any court hearings, in prison, awaiting sentencing, on probation, or have any criminal convictions, please give brief details:** |

**In the next box please provide details of why this referral is being complete. Please record past issues and problems as well as difficulties currently present.**

**Please tick the following boxes which apply to any family member being referred:**

**Abuse  \*Physical, emotional, psychological, sexual, neglect**

**Self-Harm  Attempted Suicide **

**Affected by Domestic Abuse  \*Direct / Indirect**

**Separation Issues  Bereavement, Loss **

**Section D**

**Referrer Details:**

*Relationship / Role in Family (eg: mother, son, family worker, doctor):*

*Full Name:*

*Your / Agency / Organisation Address: (if not a member of the family):*

*Phone Number: Mobile Number:*

*Email Address:*

*Date Referral Completed:*

*Referrers Signature:*



 **Return Forms to: The Arts of Change,
 27 Holloway Chambers,**

 **Priory Street, Dudley,
 West Midlands,
 DY1 1HA. 01384 211 168**

 **Email: - support@theaoc.org.uk**