|  |  |
| --- | --- |
| If applicable:  Referring Organisation: | If applicable:  Referrers Name: |
| If applicable:  Referrers Contact Details: | Date of Referral: |
| Parent/Guardian 1 Name:  Address:  Tel:  Email:  Employment: | Parent/Guardian 2 Name:  Address:  Tel:  Email:  Employment: |
| Is the child in the care or under the protection of social services?  Yes No  (If yes please provide the details of the social worker below)  Name:  Telephone:  Email address: | |
| Child details  Name:  Date of Birth:  School:  Living with: | |
| Reason for Referral: | |
| Does this child have any disabilities or special educational needs?  Yes No  (If yes please provide the details of any accommodations or additional support needed below): | |
| Days & Timings of when child could attend counselling appointments: | |
| Any further background information that may be relevant: | |
| So that we can make counselling as engaging and enjoyable for the child as possible could you please list any interests or activities that the child likes doing below: | |
| So that we can complete an initial assessment of the child’s needs, can you advise of the best day or time for us to contact the parent/carer/guardian? | |

I give consent for the above information to be used in assessment of my child.

Sign……………………………………….. Date …………………………

Your completed form will be assessed by a qualified counsellor, who will contact you regarding the next step in our process of counselling provision.

Should you have any questions please feel free to get in touch either by email; [admin@lighthousecounselling.org](mailto:admin@lighthousecounselling.org) or telephone 01384 239222.

You can return the completed form via email to [admin@lighthousecounselling.org](mailto:admin@lighthousecounselling.org)

Post or deliver by hand to;

**The Lighthouse Centre**

**Lighthouse Counselling**

Salop Street,

Dudley,

DY1 3AT