**TBF Ref No:**

THE BUTTERFLY ROOM REFERRAL FORM

Please complete this form fully and return to [admin@thebutterflyroom.org](mailto:admin@thebutterflyroom.org)

In order to progress your referral, and if you have not already done so, please [book](http://www.thebutterflyroom.org/contact.html) a free consultation call with us via our website contact page.

(**Please note**: this does not apply if you are making a referral from a **local authority** or an **educational institute -** you will be contacted directly by a member of our team to progress)

|  |  |  |
| --- | --- | --- |
| Child’s Name: | DOB: | Gender (please tick)  Male Non-Binary  Female Transgender |
| Parent/Carer Name: | Referrer’s Name: | |
| Child’s Home Address: | Referrer’s Address: | |
| Telephone (mobile preferred) | Telephone: | |
| Email: | Email: | |

|  |  |
| --- | --- |
| Child’s Diagnosis: | |
| Family Status *(please circle)* Both Parents Lone Parent Step Carer (e.g. Foster Carer, Grandparent) | |
| Is the child subject to a Child Protection Plan? Yes/No  If yes please state category: | Is the child a ‘Looked After Child’? Yes/No  If yes, please state type of placement: |
| Is the child known to and/or been known to Social Services? Yes/No  If yes, please provide the social workers details including name, contact number and email address | |
| Are there any safeguarding issues? Yes/No If yes, please give details: | |
| Please provide details of any other agencies involved with the child: | |

|  |  |  |
| --- | --- | --- |
| Child’s GP Name and Address: | | GP Telephone Number: |
| Child’s School Name & Address: | | Teacher Name: |
| School Year: |
| Telephone: | | Email: |
| EP: | YES NO | NAME: |
| LSA: | YES NO | NAME: |
| BEHAVIOUR SUPPORT | YES NO | NAME: |

Reason for referral

**Please provide us with as much information as possible to enable us to have an understanding as to your concerns and reason for referral (please use separate sheets if required)**

|  |
| --- |
| Please describe the behaviour(s) that concerns you: |
| What do you think is the cause of the behaviour? |
| Please provide us with any other relevant information that we should be aware of (e.g. family changes, trauma) |
| What do you hope will happen as a result of seeing the Behaviour Therapist/Counsellor? |
| Where did you hear about us? |

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrer

**Before we are able to accept and process any referral, we require the child’s parent/carer to confirm that they are aware and consent to, this referral being made.**

*Whilst by law, we only need to obtain consent from one party with parental responsibility, by signing your consent to therapy, we are assuming that both parents/carers are giving their consent, if this is* ***NOT*** *the case please tick to indicate this*

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Carer

**Please be aware that peak hour time slots will be offered in blocks of 10 sessions. There will be potential to review and extend, should your therapist feel this is needed.**

Please remember, if you have not already done so, to [book](http://www.thebutterflyroom.org/contact.html) a free consultation call with us via our website contact page to progress your referral (this does not apply if you are making a referral from a **local authority** or an **educational institute)**

Parental Consents

**Parents/Carers must read, complete and sign the following section. Referrals CANNOT be accepted and processed without this information and consent.**

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sharing of Information

I understand that personal information is held about me and/or my child. Personal information is made up of basic and additional information - basic information means name, address, gender, date of birth, school attended, GP, parents or primary carer etc. Additional information includes any identified needs you/your child may have and how they may be met. It may include relevant sensitive information such as ethnic origin, religion, mental health, sexual health, offences alleged or committed etc.

Yes, I understand and consent to personal information being held about me/my child

In order to provide your child with the best treatment, occasionally we may need to share this information with other services including healthcare and/or education professionals, **this will be discussed with you beforehand**.

Yes, I agree to my/my child’s basic and/or additional information being shared between services

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Carer

Your Child’s Confidentiality

Prior to beginning treatment, it is important for you to understand our approach to child therapy and agree to some rules about your child’s confidentiality during the course of his/her treatment. Therapy is most effective when a trusting relationship exists between the therapist and a child. Privacy is especially important in securing and maintaining that trust. It is necessary for children to establish a “zone of privacy” with their therapist that allows them to feel free to discuss personal matters. Therefore, it is our policy to provide you with general information about the treatment of your child, but your child’s therapist will not share with you what your child has disclosed without your child’s consent. However, if we ever believe that your child has been abused or is at serious risk of harming him/herself or another, we will inform you immediately. We will also inform you if it is necessary to refer your child to another mental health professional.

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Carer

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For office use only**

Please complete the invoicing details below - please note our invoices are sent via email and sessions **can not** begin without the below information.

|  |
| --- |
| Name and address that invoices should be addressed to: |
| Email where invoices should be sent: |
| If known, the total number of sessions to be invoiced: |
| Please provide details of any information that needs to be included on your invoice i.e. patient surname, PO number etc. |

If relevant, please provide us with any further information in relation to invoicing, that we need to be aware of: