



WANTED NOT WASTED

# REFRAME Counselling

## Referral Form

Name of Child/Young Adult.....

D.O.B.....

Address and contact details.....

.....

Ethnic Classification

Information not obtainable

White

Black/Black British

Asian/Asian British

Chinese/Other Ethnic

British

  
  

Caribbean

African

Other Black

  
  

Indian

Pakistani

Bangladeshi

Other Asian

  
  
  

Chinese

Any Other

  

White/Black Caribbean

White/Black African

White/Asian

Other mixed

  
  
  

PREFERRED LANGUAGE (other than English):

Is the child/young person disabled?

Y / N

Details

**Is there parental consent for this referral?** (if under 16 yrs old)

**Is the child/young person in education or work?**

Please specify where

**Reason for Referral** (please specify any previous counselling where known and if self harming, and or misusing drugs and alcohol where known.)

**What level of support would you say this child/young person needs?**

Long term 12 sessions or more

Short term 6 sessions or less

**When would you like the support to start?**

**Who would be the best person to contact re this referral and arrange the time to see the young person?** (this can be young person, referrer, family member or other)

Name.....Role.....

Email:.....Address.....

Tel and extension number.....

**Please Return To:**

Helen Roy WOW Coordinator

35 Totterdown Road

Weston Super Mare

North Somerset

BS23 4LH