| **Client number**(for office use only) |  |
| --- | --- |
| Date of referral |  |
| Preferred name of child / young person |  |
| Name if different from above |  |
| Preferred pronouns of child/young person (eg he / her / they) |  |
| Age at time of referral |  |
| Date of Birth |  |
| Parents / carers (name and relationship to child) |  |
| Family contact details (Please include address, telephone numbers **and** email addresses of all parents/carers) |  |
| Person making this referral |  |
| Contact details  |  |
| School or college (if the young person is in work, please indicate this - we don’t need specific details of the workplace) |  |
| Source and any limitations of funding |  |
| Desired start date |  |
| What referrer and family are looking for(therapeutic outcomes) |  |
| We usually include one meeting with the referrer and one ending report in our quote. Please state here if you require any additional meetings or reports, as this will need to be included in our costing. |  |
| Overview of situation (Please include the child or young person’s background, any concerning behaviours, relevant information about the family situation) |  |
| Please ask the family to list **ALL** the times and days they are available to bring the child/young person to the centre for appointments.(We are not able to accept referrals without this information)The more options they are able to provide, the quicker we can offer therapy. Please note that the wait for appointments outside school times is likely to be considerably longer |  |
| Does the child / young person or family have any learning difficulties, communication needs, or neurodiversity? |  |
| Does the child / young person have an EHCP? |  |
| Does the child / young person or family have any medical or access needs that will affect their ability to access therapy?(The Apple Tree Centre is spread over several floors and we do not have a lift) |  |