**Children and Young People’s Referral Form: Supporting families**

**With Serious or Terminal Illnesss**

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| **Name of child/young person being referred:** | | **D.O.B:** | **Age:** |
| **Ethnicity:** | **Gender:** | **Language:** | **Religion:** |

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| **Name of primary/secondary school child attending:** | 1. **GP Name and Address:** 2. **Does the child/Young person have a disability?** *This could be learning or physical* 3. **Is the child/YP Neurodiverse? E.g***. ASD, ADHD,* 4. **Any other medical conditions?**: |
| **Family information**  **Main carer(s) and relationship to child**:  **Address:**  **Daytime contact number:**  **Evening contact number:**  **Email**:  **Siblings**  **Name:** **Age:**  **Name:** **Age:**  **Name:** **Age:** | |

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| **Reason for referral:** |
| **Is the child or young person aware this referral is being made?** |

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| **Name of family member who is ill:** | **Relationship to child/young person:** | **Age:** |
| **Type of illness:** | | |

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| **Family Tree (useful if you can provide):** |
| **Children’s support network (Including professional services – school, CAMHS):** |

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| **Any other significant losses/events/risks:** *(e.g. moved home, school, issues around birth, early development, bereavements, self-harm, suicidal thoughts or mental health concerns)* |
| **Any further relevant information which you feel will be helpful?**  **Please include family spiritual or cultural beliefs and traditions** |
| **Where did you hear about the service?:** |

**permission for child/youNG Person to attend Bereavement suppport therapy**

**I/we:**

**Relationship to the child (Parent/guardian/carer):**

**Give consent for** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **To receive bereavement therapy support. Confidentiality and assessment will be discussed, clarified and agreed prior to the sessions starting.**

***Signature of parent/guardian/carer:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Professional making referral:**

**Name:**

**Organisation:**

**Family permission to make referral: YES / NO**