

**Children and Young People’s Therapy - Brighton**

**Referral Form**

**Individual therapy for young people affected by a family member’s substance misuse**

**Initial contact / Referral made by**: Parent/carer / agency/ other (please state)

Name:

Address:

Tel:

E-mail:

Date of referral:

**Has the young person and/or their parent/carer given explicit (written) consent to sharing this referral and the personal information it contains with Young Oasis?**

YES / NO

**Date consent was given:**

# Contact Information

## Young person’s details:

Surname: First name (s):

Date of birth: Gender (M/F/Other:

Address:

Postcode:

Young Person's tel (optional):

Young Person's e-mail (optional):

## Details of Parent(s) or main Carer(s):

Name: Relationship to child / young person:

Address:

Postcode:

Home tel:

Mobile tel:

e-mail:

## Second parent / carer:

Name: Relationship to child / young person:

Address:

Postcode:

Home tel:

# Professional Involvement

## Lead Professional:

**Does the child have a lead professional involved? (Eg. Social Worker)**

Name of LP:

Role/title:

Agency / team: Tel:

## Doctor (GP):

Name:

Address: Tel:

Is the child/young person on medication? (Y/N)

## School:

Name:

Address: Tel:

Teacher / tutor name: Class / form:

Is the child/young person eligible for free school meals? (Y/N)

## Other agency:

**Please specify type of support previously received**

Name:

Address: Tel:

## Counselling/therapy experience

Please specify -who/ where/when if possible

Has the child/young person attended Young Oasis;

Creche/ therapy service/Holiday art group

# Reason for Referral / Identified Needs of Young Person

**Please include relevant background information. Substance use within the family/ Health / Emotional and social needs / Family relationships/ School issues.**

# Contact preferences

**Who would the Young Person prefer Young Oasis to make contact with?**

Him/herself / parent/carer / other (please state)

**How?**

via phonecall / text / letter / e-mail (please circle)

Does the young person wish this referral to be in confidence?

Is an interpreter or signer required?

**Signature**

**Signature . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Date . . . . . . . .**

**Signed by:**

**School / other agency**

**Parent /carer**

**Young person**

**Other (please state)**

**When completed, please send this form to**

**youngoasistherapy@oasisproject.org.uk**

**or post to; Young Oasis Therapy, Globe House, 3 Morley Street, Brighton, BN2 9RA**

**Tel. 01273 696970 ext 0303.**