**Creative Therapy Referral Form**

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| Referrer:  Email:  Contact number:  Date: |  | |
| Name of Young Person |  | |
| D.O. B |  | |
| Address  Contact number |  | |
| What would you like for the young person to develop or work on during therapy? |  | |
| Why is the young person known to your service & are they known to another service. E.g: YOS, CAHMS, Probation etc |  | |
| Risk Assessment  (Tick the relevant applicable life experience related to the referred young person)  If other, please specify | * Causing harm to others * Allegation towards professionals * Learning difficulty - SEMH * Learning difficulty – SEN * Substance misuse * Other: | * Suicidal Ideation * Self-Harm * Child Criminal Exploitation * Child Sexual Exploitation * Anxiety * Low self-esteem * Depression |
| What area does the young person reside?  What area do they feel  Less safe in? |  | |
| How would you describe the young person’s interaction with professionals - (e.g. withdrawn, bubbly, open, responsive, disengaged, talkative stubborn etc) |  | |
| Does the young person have relevant interests (e.g. music, art, drama, football, basketball etc) |  | |
| Are you aware of any childhood adverse experiences or current traumas?  Any known triggers |  | |