**Creative Therapy Referral Form**

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| Referrer:Email:Contact number: Date: |  |
| Name of Young Person |  |
| D.O. B |  |
| AddressContact 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
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| 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| How would you describe the young person’s interaction with professionals - (e.g. withdrawn, bubbly, open, responsive, disengaged, talkative stubborn etc) |  |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  |  |