|  |
| --- |
|  |

 **Referral Form: Please complete the boxes in**

 **white only. Grey boxes are for MACP office use only**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Counselling: Please tick** | **By Zoom** |  | **Face to Face** |  | **Telephone** |  |
| **Counsellor Allocation** | **Office Use** |
| **Client Reference No** | **Office Use** |
| **MACP Assessor Recommendations** | **Office Use** |
| **Information captured by: (MACP Representative)** | **Office Use** | **Date** | **Office Use** |
| **Referrer/Client/Organisation** |  | **Tel No** |  |
| **Organisation & email:** |  |
| **Is the child or young person in contact with any other organisations? If yes, who?** |  | **Is the child or young person on the “At Risk” register?** |  |
| **Is there any other agency involved?** |  | **If applicable, name/contact details of social worker** |  |
| **Name of GP, address, contact details** |  |
| **Client Details Only: Please note if the client is under the****age of 16, a parent or carers details should be inserted below** |
| **Name** |  |
| **Address** |  |
| **Email address** |  |
| **Client Age** |  | **Date of Birth** |  |
| **Client Mobile No:** |  | **Home Number** |  |
| **Client Presenting Issue** |  |
| **Client Preferred Contact** |  |
| **Next of Kin**  |  | **Next of Kin Tel No:** |  |
| **Are there any risk factors MACP should be made aware of e.g., Suicide, self-harm, violence towards others etc. Please insert a number from 0-10,****0 being no risk, 10 being risk imminent** | **Suicidal Tendencies** | **Self-Harm** | **Harm to others** |
|  |  |  |
| **Availability for Appointments. Please tick** | **Mornings** **9am-1pm** | **Afternoon** **1pm-5pm** | **Evening** **5pm – 9pm** | **Weekends****9am – 9pm Sat/Sun** |
|  |  |  |  |
| **Any Other Information** |  |