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**Family Counselling Trust – Standard Referral Form**

**IMPORTANT GUIDANCE for Referrers**

FCT is a charity supporting children and adolescents up to 18 years in need of counselling in an inclusive service involving the families. We are an ‘early-intervention’ mental health service seeking to provide a rapid response. FCT offers six sessions of counselling. FCT accepts referrals of children with: anxiety, depression, anger issues, bullying dynamics, mild obsessive behaviour, displays of aggression, family communication and relationship difficulties.

FCT cannot accept referrals of: Looked After Children, children on a Child Protection Plan/Order, young people with symptoms of severe eating disorders, possible psychotic behaviour and safeguarding issues.

Household income determines family contributions towards counselling – FCT uses four income bands to assess this (shown on Page 3).

**Before completing and returning this form, please ensure the parent/carer has spoken to the child/young person and explained that you may be seeking counselling. As we are keen to make the best use of our resources, it is important that the child/young person is willing.**

**To make a referral to FCT please complete this form, provide information for all details specified below and send it to the appropriate email address (please see end of Page 3).**

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| **Full details of who we can and cannot offer counselling to can be found here:** [**https://www.familycounsellingtrust.org/professionals**](https://www.familycounsellingtrust.org/professionals) | | | | | | | | | | |
| Please confirm you have checked this referral fits into our early-intervention mental health criteria: | | | Yes: |  | | No: | | |  | |
| **Please note: if the referral is considered outside of our model &/or too complex it will be returned.** | | | | | | | | | | |
| **REFERRER’S DETAILS:** | | | | | | | | | | |
| Date of referral: |  | Referrers name: | |  | | | | | | |
| Agency: |  | Contact number: | |  | | | | | | |
| Email: |  | | | | | | | | | |
| Please confirm that the child/young person has consented to this request for support: | | | | | Yes: | |  | No: | |  |

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| **REFERRED CHILD/YOUNG PERSON:** | | | | | | | | | | | | | | | |
| First name: |  | | Surname: | | |  | | | Preferred name: | | | |  | | |
| Age: |  | | DOB: | | |  | | | Gender identified with: | | | |  | | |
| **GP DETAILS:** | | | | | | | | | | | | | | | | |
| GP Surgery: | | |  | | | GP phone number: | | |  | | | | | | | |
| GP Address: | | |  | | | | | | | | | | | | | |
| GP Email: | | |  | | | | | | | | | | | | | |
| **PARENT/CARER’S DETAILS:** | | | | | | | | | | | | | | | | |
| **Our Family Liaison Officer will need to speak with the family in order to process the referral. Please let us know the best way to make initial contact:** | | | | | | | | | | | | | | | | |
| Name(s): |  | | | | | Phone number: | | |  | | | | | | | |
| Address: |  | | | | | | | | | | | | | | | |
| Email: |  | | | | | | | | | | | | | | | |
| Preferred method of contact (X in the box): | Phone |  | | Text |  | | Email |  | | Any |  | | | | | |
| Best time to contact: | AM |  | | PM |  | | Please note our Family Liaison Officer will contact you during weekday office hours. | | | | | | | | | |
| Are the parents separated? | | | | | | | | | | Yes: | |  | | No: |  | |
| If YES, does the other parent know about this referral? | | | | | | | | | | Yes: | |  | | No: |  | |
| Does the parent/carer give permission for their contact details to be given to the counsellor if the referral is accepted? Yes/No | | | | | | | | | | Yes: | |  | | No: |  | |

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| **CONTACT DETAILS FOR YOUNG PERSON (IF 16 OR OVER)** | | | |
| **If it is ok for our Family Liaison Officer to contact the young person directly, please let us know the best way to do so initially:** | | | |
| Address: |  | Mobile: |  |
| Email: |  |
| **HOW CAN WE CONTACT THE YOUNG PERSON (IF 16 OR OVER)?** | | | |

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| Preferred method of initial contact: | Phone |  | Text |  | Email |  | Any |  |
| Best time to contact: | AM |  | PM |  | Please note our Family Liaison Officer will make contact during weekday office hours. | | | |

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| **REFERRAL DETAIL:** | | | | | | | | | | | | | | | |
| Has CAMHS been considered? If not, why not? Please advise if a referral elsewhere is being considered at this time: | |  | | | | | | | | | | | | | |
| **SUCCINCT DESCRIPTION OF THE PROBLEM WITH IMPORTANT DETAIL** | |  | | | | | | | | | | | | | |
| **DO YOU HAVE ANY SAFEGUARDING CONCERNS? If YES, please specify what action you have taken.** To include any Police or Court involvement. | |  | | | | | | | | | | | | | |
| Do the family/child wish to be considered for telephone or online therapy: | | | | Yes: |  | | No: | | | |  | | | | |
| Or prefer face to face therapy when available (re: latest Pandemic Guidance)? | | | | Yes: |  | | No: | | | |  | | | | |
| **Please tick next to the relevant JOINT HOUSEHOLD INCOME band –** after consulting with the family: | | | | | | | | | | | | | | | |
| **BAND A - Up to** £28,000 pa including benefits (family contributes £5 per session) | | | | | | | | | | | | |  | | |
| **BAND B -** £28,000 - £38,000 pa including benefits (family contributes £20 per session) | | | | | | | | | | | | |  | | |
| **BAND C –** £38,000 - £46,000 pa including benefits (family contributes £30 per session) | | | | | | | | | | | | |  | | |
| **BAND D -** Over £46,000 pa including benefits (family pays counsellor full session cost directly. This is £60 for the first session and £50 for subsequent sessions. Please be aware there is a one off £45 admin fee to process the referral once FCT has contacted the family and processed the referral, and to pay whether counselling can be offered or not.) | | | | | | | | | | | | |  | | |
| Please note: if families can’t afford the contribution per session this can be discussed with the FLORA.  **\* If families would like to contribute more for their sessions then this is most welcome and helpful.** | | | | | | | | | | | | | | | |
| Is this child/family eligible for Pupil Premium? | | | | | | Yes | | |  | No | | | |  | |
| Will the school be paying for the cost of the sessions? | | | | | | Yes | | |  | No | | | |  | |
| **(If Yes, please note that the school pays the full cost per session regardless of the family income band)** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **REFERRER’S SIGNATURE:**  **(**signing for accuracy of detail and that the referral comes with the consent of the parent(s) named above): | | | | | | | | | | | | | | |
| Print name: |  | | Signature: | |  | | | Date: | | | |  | | |

**Please Send this Form to the appropriate County FCT Family Liaison Officer:**

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| **Dorset FCT Family Liaison Officer – Kay Parkinson**: | | | |
| Email: | [flo-dorset@familycounsellingtrust.org](mailto:flo-dorset@familycounsellingtrust.org) | Tel: | 07772 101649 |
| **Hampshire FCT Family Liaison Officer – Fiona Atkins:** | | | |
| Email: | [flo-hampshire@familycounsellingtrust.org](mailto:flo-hampshire@familycounsellingtrust.org) | Tel: | 07754 253382 |
| **Somerset FCT Family Liaison Officer – Liz Loud:** | | | |
| Email: | [flo-somerset@familycounsellingtrust.org](mailto:flo-somerset@familycounsellingtrust.org) | Tel: | 07513 808849 |
| **Wiltshire FCT Family Liaison Officer – James Poynting:** | | | |
| Email: | [flo-wiltshire@familycounsellingtrust.org](mailto:flo-wiltshire@familycounsellingtrust.org) | Tel: | 07375 535407 |

Family Counselling Trust acknowledges that the welfare of the individual is paramount: Privacy and Confidentiality will be respected where possible but if doing this leaves a child at risk of harm, then the child’s safety will always come first.