**CCATS**

**INITIAL REFERRAL**

|  |  |
| --- | --- |
| **Service requested:** *please delete as appropriate*  -Psychological assessment  -Psychological therapy/intervention | **Client:** *please delete as appropriate*  -Young person (under 18)  -Adult (18 or over) |

**1. Client’s Details:**

|  |  |  |
| --- | --- | --- |
| Surname: | Current Address: | Date of Birth: |
| Forenames: | Gender: M / F |
| Contact telephone:  Email: | Post Code: | Ethnic Origin: |

**2. Referrer’s Details:**

|  |  |  |
| --- | --- | --- |
| Name: | Organisation: | Job Title: |
| Address: | Contact Numbers:  Work:  Mobile: | Email Address: |

**3. Other agency’s details**

Please provide details of the other relevant agencies who are involved (e.g. Social Worker).

|  |  |  |
| --- | --- | --- |
| Social Worker:  Name: | Address: | Contact Number(s) |
| Job Title:  Name: | Address: | Contact Number(s) |

**4. Reason for Referral:**

(Please continue on a separate sheet if necessary)

|  |  |
| --- | --- |
|  | |
| **Please tick whether you would be happy for sessions to be:** | |
| Face to face (there may be a longer wait for this) |  |
| Via video call (if client has the means and ability for this) |  |
| Either face to face or via video call |  |

**5. Please give details of any medication the client is currently taking.**

|  |  |
| --- | --- |
| Medication: | Dosage: |
| Medication: | Dosage: |

**6. Is the client aware of this referral? Yes / No**

**6.1 If no**, please give reasons in the box below.

|  |
| --- |
|  |

**7. Signatures and consent**

**7.1** I have read the contents of this form and consent to this referral. I give my permission for CCATS to contact the agencies listed in section 3 of this form if required and share information relevant to the client’s mental and emotional health. *This section should be completed by the client, or by a person with parental responsibility for the client, if they are under 18.*

Signature: .................................................................................

Print Name: .............................................................................

Date: .......................................................................................

**Please send the completed referral form to** [**info@ccats.org.uk**](mailto:info@ccats.org.uk)**.**

**If the person making this referral has access to psychological or psychiatric reports regarding the client, these should be sent along with this completed form. CCATS may request additional information on receipt of this referral.**