E S C A Y P™

Emotional Support for Children And Young People

Patron: Mr. Paul Wombwell

Registered Charity Number 1127715

PLEASE COMPLETE BOTH SIDES OF THIS REFERRAL FORM AND SIGN THE CONSENT AT THE END OF THE FORM

Information about the Child or Young person being referred

Please answer all questions using BLACK ink

Name	Date of Birth
Address Post Code _____ Council Area?	Male Female _____ Kirklees, Leeds, Bradford, Wakefield, Calderdale
Telephone number with area code	( )
Mobile number	
Can we leave a message?	YES NO
School/College/University attending	
Religion	
What is the Young Person's ethnicity	

Is the young person receiving any support from other 'professionals'?	YES NO Who?
Is the young person on a 'waiting list' for any other counselling services?	YES NO
Is the young person aware of the referral to ESCAYP™	YES NO
Does the young person have any special needs e.g. interpreter, access? _____ Please state preferred gender of counsellor.	YES NO _____ Male Female No Preference

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Information about the person making this referral

Name Address Post code	Telephone number with area code ( ) Mobile number Email address
Referring Agency/organisation	
Relationship to young person e.g. Parent/Relative/Self Referral Support Worker etc	

Young person's main carer

Mr. Mrs. Ms Miss Name Address Post code	Home telephone number with area code ( ) Mobile Number Can we leave a message? YES NO
Relationship to young person? e.g. Mother/Father/Grandparent/Foster or Adoptive parent	

Does the Child/Young person have any Health Issues that we need to know about?
YES NO

If yes, please briefly state what they are

_____

_____

Is the child/young person classed as having a disability? YES NO
If yes please state _____

Is this the first referral to ESCAYP? YES NO
Are there any present/previous family members referred to ESCAYP? YES NO
Name(s)_____

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Is there an ongoing or pending court case? YES NO

Name of Police Liaison Officer_____

Tel:_____

Do we have your permission to contact your parent/carer? YES NO

Who advised you to make this referral? _____

GP name: _____

Address: _____

Telephone number: _____

All counselling is carried out on a 1 to 1 basis.

Please Note:

Any information given by the referrer may be shared with the young person. All information from the young person will be confidential, but will be within the guidelines of the Child Protection and Safeguarding Board and the British Association for Counselling and Psychotherapy (BACP)

By signing this form you are giving your consent to the above named person receiving Counselling or Therapeutic Play from ESCAYP™

This form must be signed by the parent/guardian of the child being referred or the person referring themselves if over 16 years of age.

Signature _____ Date_____

Print Name _____

Relationship to child/young person? _____

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Our current contact details:

Office Number: Tel: 01274 878117

ESCAYP: **help@escayp.org.uk**

Sarah Walkin Administrator
admin@escayp.org.uk

Jackie Bould -Director
Email: **Jackie@escayp.org.uk**

Heather Pearce – Coordinator
Email: **admin@escayp.org.uk**

Tina Waddington-Coordinator
Email: **admin@escayp.org.uk**

Website: www.escayp.org.uk

If you wish to print and post this form, please send to:

ESCAYP Counselling Services
RED DOOR
REAR of 258 Oxford Road
Gomersal
BD19 4PY

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We will confirm receipt of this form within 48 hours. If you have not had confirmation in this time please ring 01274 878117

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