*Please ensure* ***all*** *fields are completed and return by post or email:* 

**apricotcentre**

**South Devon:** Apricot Centre for Wellbeing
Huxhams Cross Farm, Rattery Lane, Dartington, Totnes. TQ9 6AA

wellbeing@apricotcentre.co.uk

|  |
| --- |
| **Referral Form with Consent for Information Sharing & Therapy** |
| Private referral ☐ School referral\* ☐ Local Authority referral ☐ Other: …………………………………..Name of Referrer: ……………………………………… Organisation: ……………………………………..Contact number of referrer: ………………………….. Contact email: …………………………………….\*If this is a School referral - Please confirm whether the school has a policy/consent for basic therapeutic work with outside agencies from the parents - (NB this will be sufficient for groupwork but not full therapy work). Yes / No |
| **Date of referral:**  **Client/s name/s:**    DOB:  NHS No: Ethnicity:  | Looked after Child ☐ Adopted Child ☐Special Guardianship ☐ Child Arrangement Order ☐ Kinship Care ☐ Child with Birth parent/s ☐ Other ☐(please specify)..................................... Adult - Over 18 ☐ |
| **Parent/Carer 1 (name):**Role: **Parental responsibility** Yes / No**Will you be giving consent for therapy?** Yes / NoAddress (w/ postcode): Mobile No:Tel. No: Email: **Parent Carer 2 (name):**Role: **Parental responsibility** Yes / No**Will you be giving consent for therapy?** Yes / NoAddress (w/ postcode): Mobile No:Tel. No: Email:  | **Social Worker (name):****Parental responsibility** Yes / No **Will you be giving consent for therapy?** Yes / No Address (w/ postcode): Mobile No: Tel. No: Email:  **Other Responsible Adult (name):**Role:**Parental responsibility** Yes / No **Will you be giving consent for therapy?** Yes / No Address (w/ postcode): Mobile No:Tel. No: Email:  |
| **GP Surgery:****GP Name:**  GP Address (w/ postcode): Tel No:  | **School name:****Main Contact** (Name & Role)**:** **Other Contact** (Name & Role)**:**School Address (w/ postcode): Mobile/Tel: No: Email: |
| **Referral information** (please describe in terms of the young person’s needs, your wished for outcome/s, and any useful background information you can supply)**Risk assessment - Please state any present known risks to self and others.**  **Any other professional known to be presently involved (tick):** Educational Psychologist ☐ Social Worker ☐ PMHW ☐ Health Visitor ☐ School Nurse ☐ Paediatrician ☐ SALT ☐ OT ☐ Other (please specify) ……………………………………….**Child Protection Plan -** If relevant, please describe any previous or child protection involvement/plan Current plan ☐ Previous plan ☐ Not aware of plan ☐ **Is there any court involvement we should be aware of?** Yes / No |
|   **For us to take this referral further we need consent from a parent and a child over 13, or young people over 16 can also give consent. On the next page is a consent form to help us know how you wish for us to proceed.** If you are not the parent or young person but represent an agency supporting the child or family, please sign below, and help us to ensure that consent is given by the parent/child using the form on the next page.**Signed** ……………………………. **Name** ……………………………. **Date** …………………………….**Agency** ……………………………. **Role** ……………………………. |

**Consent to us holding your information and who we can share it with**

**Privacy Notice** - Your work with us is confidential to our team. This means we won’t keep or share your personal information unless you agree, except if there are safeguarding concerns which we must respond to. We only use your information to work out how to best support you and for no other purposes (such as marketing etc..)

Please sign this agreement if you agree to us holding referral information about you/your child, and show who you are happy and not happy for us to share relevant information with. This form should be signed by responsible adult/parent and where appropriate by the young person (13+). Young people over 16 can sign consent for themselves.

**Client name** (or names where a family group) **1.** ……………………………. **Date of Birth:**

2.……………………………. **Date of Birth:**

3. ……………………………. **Date of Birth:**
4. ……………………………. **Date of Birth:**
5. ……………………………. **Date of Birth:**

o I understand that information is held on a secure Apricot Centre database, and/or a copy will be held on a physical file which will be stored in a locked filing cabinet

o I agree that personal information may **only** be shared with other people agencies and professionals if they are named below:

 **People we can share information with:** ………………………………………………………………………………………………………………...……………………………………………………………………………………………………...

**People we must not share information with:** ………………………………………………………………………………………………………………...……………………………………………………………………………………………………...

**Parent/Carer (if young person under 16)**

Name: Signature:

Date:

**Young Person or Adult (if person 16 or over)**

Name: Signature:

Date: