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| **Young person’s name:** | **Date of birth:** | **Date:** |
| **Name of referrer:****Organisation:****Contact telephone:****Contact email:** | **Preferred contact for appointment****Name:****Relationship to Young person:****Mobile no:** |
| **Young person’s address and postcode:** | **GP Surgery and address:** |
| **School attended:** | **GP telephone number:** |
| **Gender identity:** | **Ethnicity:** |
| **Brief details of any health related issues:** | **Preferred gender of counsellor?** |
| **Details of other agencies involved or other support currently in place:** | **Brief details of any previous counselling;** |
| Young Person’s Signature required to say: **I am informed and aware of what counselling is and I** **give consent to this referral?** Signed (Young Person):  |
| **Brief detail of any additional needs:** |
| **Reasons for referral to counselling:** |

Please return this form to pauline@step2.org.uk