

**Arts Therapy Referral Form and Risk Assessment**

**for face to face or online sessions**

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| **Date of referral:** |  |
| **About the young person** |  |
| Name: |  |
| Date of birth: |  |
| Their current age: |  |
| Their preferred pronouns: |  |
| Address/ or addresses if moving between two addresses: |  |
| Name of parent/carer with parental responsibility: |  |
| Email of parent/carer: |  |
| Phone numbers: |  |
| Contact details for parent/carer:  (two methods please) |  |
| GP name, address and telephone: |  |
| Is the young person in education, employment or training? If so - please give details: |  |
| **About the referrer** |  |
| Name: |  |
| Organisation and/or role in relationship with the young person: |  |
| Address: |  |
| Email: |  |
| Phone numbers: |  |
| **About the referral** |  |
| Has this referral been made with the young person? | Yes [ ] No [ ]  Notes (if needed): |
| Reasons for referral:  (please continue on separate sheet as needed) |  |
| What would the young person like to get out of any arts therapy sessions? |  |
| Does the young person have any specific mental health difficulties, learning disabilities or conditions?  Please give details: |  |
| Does the young person have a formal diagnosis?  Please give details: |  |
| Please give details of any medication the young person is taking or carries with them related to any medical condition: |  |
| Does the young person have a history of support, from CAHMS? Please give details and someone we can contact to discuss: |  |
| Has the young person had any previous experience of therapy or counselling? Please give details: |  |
| Does the young person have any communication or accessibility needs?  Please give details: |  |
| Does the young person have any special interests, skills or aspirations you would like us to be aware of?  Please give details: |  |
| Does the young person have any preferences at this stage? (E.g. group or individual therapy, face to face or online sessions, a particular project you have heard about). |  |
| Does this young person have access to a phone with camera, tablet with camera or computer with camera? Please note if this is a barrier we will try to help with this. |  |
| Does this young person have access to the internet? |  |
| Anything you would like us to be aware of?  Please give details: |  |
| **Finances** |  |
| Does the young person have access to funding through social services/Early Help/Adoption Support Fund/DLA/school/pupil premium/local provider/privately paying/other?  Please give details: |  |
| Please indicate the total family income band (if you would like to be considered for grant and donation funded sessions). | Under £20,000 pa [ ]  Between £20,000-£30,000 pa [ ]  Between £30,000-£40,000 pa [ ]  Between £40,000-£50,000 pa [ ]  Over £50,000 pa [ ]  (Income to include any benefits) |
| **Consent** |  |
| Does the young person give consent to this referral? | Yes [ ] No [ ] |
| Does the parent/carer with parental responsibility give consent? (if child under 18) | Yes [ ] No [ ] |
| Does the young person give consent for us to contact their GP/parent/other services as necessary? | Yes [ ] No [ ]  Notes (if needed): |
| Please list 1 or 2 preferred contacts the young person is happy for us to contact following sessions should we need to. | Name:  Relationship:  Contact telephone numbers:  Name:  Relationship:  Contact telephone numbers: |

**Arts Therapy Referral Initial Risk Assessment**

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| --- | --- |
| **Date completed:** |  |
| **Name of person completing:** |  |
| **Who completed with:** |  |
| **Name of young person:** |  |
| **Risk Assessment** |  |
| **Self-harm:** |  |
| Is the young person currently self-harming? | Yes [ ] No [ ]  Notes: |
| Does the young person have a history of self-harming? | Yes [ ] No [ ]  Notes: |
| **Self-neglect:** |  |
| Does the young person have current difficulties with  self-neglect? | Yes [ ] No [ ]  Notes: |
| Does the young person have a history of self-neglect? | Yes [ ] No [ ]  Notes: |
| **Abuse and exploitation:** |  |
| Is the young person currently experiencing abuse or exploitation? (e.g. abuse, bullying) | Yes [ ] No [ ]  Notes: |
| Does the young person have a history of abuse or exploitation? | Yes [ ] No [ ]  Notes: |
| **Suicide:** |  |
| Does the young person have current suicidal thoughts? | Yes [ ] No [ ]  Notes: |
| Does the young person have current suicidal plans? | Yes [ ] No [ ]  Notes: |
| Does the young person have a history of any suicidal thoughts, plans or attempts? (Please give dates and details of any attempts) | Yes [ ] No [ ]  Notes: |
| **Risk to others:** |  |
| Does the young person have a history of being a risk to others? (e.g. aggressive behaviours, arson) | Yes [ ] No [ ]  Notes: |
| Does the young person have any communication or accessibility needs?  Please give details: | Yes [ ] No [ ]  Notes: |
| Does the young person have any preferences at this stage? (E.g. art or dramatherapy). | Yes [ ] No [ ]  Notes: |
| **Other risk factors:** |  |
| Does the young person have a history of drug or alcohol abuse? | Yes [ ] No [ ]  Notes: |
| Does the young person have a history of homelessness? | Yes [ ] No [ ]  Notes: |
| Does the young person have a history of disintegration with significant attachment figure?  (e.g. history of adoption, unhealthy relationship with mother/father/caregiver) | Yes [ ] No [ ]  Notes: |
| **Other risk factors not identified above:** | Notes: |

Thank you for completing these forms. Please note you may be asked to

complete an additional consent form once an offer of sessions is made.

Signed by referrer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed by young person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if possible)

We prefer form to be emailed to us, please send to

info@youthartsandhealth.org

If emailing is not possible, please print and post to YAHT Referrals, Youth Arts & Health Trust, YES Centre, 22 Cathedral Yard, Exeter, EX1 1HB marking the envelope ‘private and confidential’.

**\*IMPORTANT\***

Please password protect this referral form and any accompanying documents wherever possible.

Instructions for how to do this on Word-

1. Open the **Word** **document**
2. Click on **File**
3. Click on Info
4. On the right side, click the **Protect document** menu
5. Select the Encrypt with **Password** option
6. Type a **password** to **protect** the **document**
7. Click the OK button
8. Retype the **password**

The document will now be password protected with the password of your choice. Please send the password to[info@youthartsandhealth.org](mailto:info@youthartsandhealth.org) in a separate email or text to 07967 188 493 with the initials of the referrer.