

Creative-Connections REF. No:

**Creative Connections**

Therapy - Training – Consultation

**CONFIDENTIAL**

**Parent-Child Attachment Play Referral Form**

This form is used to make a referral for therapeutic support and will inform the child/young person’s/family assessment. The information from home and school is equally important in the assessment process, even where children only show difficulties in one of these settings. It may be that there is a different picture at home and school, but this information is important to capture so please complete as full as possible.

The form asks for very detailed information about a range of behaviours to ensure that the assessment is efficient and identifies the most appropriate support. If there is no evidence from your contact with the child/young person that they have the problems listed, **please comment on the child/young person’s usual behaviour** rather than just adding ‘no problems’. If you have information that is not covered by the form, please add it on another page. Please ensure that consent has been given to share information.

Please fully complete the form then return to:

By **secure** email: **CreativeConnections@protonemail.com**

|  |  |  |
| --- | --- | --- |
| Child’s Initials:  | Gender: Male Female  | Age: |
| Parent(s)/Carer’s Name: | Address: Telephone number: |  |
| Referrers Name: | Address:Telephone number: |  |
| Email: |  |  |
| Family Status: Both Parents Lone Parent Step Adopters Carer (e.g. Foster Carer, Grandparent) |
| Is the child subject to a **Child Protection Plan?** Yes No Please state Category: |
| Is the child a **‘Looked After Child’?** Yes No Type of Placement: |
| Is CAMHS involved and/or Pending Appointment Yes No  |
| Child’s School Name & Address:Telephone number: | Child’s School Year: |
| School’s E-mail: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Professional** | **Name of professional** | **Age of child when seen** | **Report attached** |
| Paediatrician |  |  |  |
| Speech and Language Therapist |  |  |  |
| Learning and Behaviour Support Service (LABSS) |  |  |  |
| Occupational Therapist |  |  |  |
| Educational Psychologist  |  |  |  |
| Youth Offending Service |  |  |  |
| Any other support service in place – please state- how long and if service will be continuing |  |  |  |
| Any problems with eyesight or hearing? | **YES / NO****Give details if yes** |  |  |
| Does this child have any physical health or severe co-ordination problems or any disability? Please give details: | **YES / NO****Give details if yes** |  |  |
|

|  |
| --- |
| **SECTION 3: WHAT HOPED OUTCOMES DO YOU HAVE FOR THE CHILD/FAMILY RECEIVING THERAPY?** |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **4.** |  |

**Please continue if necessary:** |
| **WHY DO YOU THINK THE CHILD/YOUNG PERSON/FAMILY MAY BENEFIT FROM SUPPORT?** Please explain the background history and reasons for referring. the symptoms you have seen. Please add plenty of details, bullet point lists are acceptable.  |
| **Person Completing Section: LA/School / Home/ other (please state)** **What behaviours concern you?****What do you think is the cause of the behaviours?** |
| **COMPARISON WITH SCHOOL/NURSERY PEERS** Please tick the best description |
| **Expressive Language (talking)** | **Better than peers** | **Similar to peers** | **Has more difficulty than peers** | **Has major difficulties** |
| **Receptive Language(understanding)** |  |  |  |  |
| **Social Interaction (relating to people)** |  |  |  |  |
| **Friendships** |  |  |  |  |
| **Play** |  |  |  |  |
| **Flexibility (adapting to changes)** |  |  |  |  |
| **Cognition (thinking) & Learning** |  |  |  |  |
| **Sensory and/or physical** |  |  |  |  |
| **Physical Development** |  |  |  |  |
| **STRATEGIES AND SUPPORT** |
| Have you used any interventions or strategies to address the child’s difficulties? If so which ones and have they been successful? |  |  |
| What are your views about what can be done to help this child? |  |  |
| **RISK AND MENTAL HEALTH** |
| Are there any concerns of risks to the child and/or worries about mental health problems?  |  |  |
| **Signature of person and role who is providing the information**  | Name | Signature  |
| Role | Date |
| I have gained consent to share information/history about the client/family **YES / NO**Name………………….Role…………………..Date…………………… |