**Community Counselling Referral Form**

**Email:** [**cypcounselling@hertfordshiremind.org**](mailto:cypcounselling@hertfordshiremind.org)

Please complete this form if you would like to access our services and we will contact you to discuss next steps. Please provide as much information as possible. Fields marked with an \* are required

**Date of referral**

Date:

**Your details**

Name\*       Surname\*

Preferred Name

Preferred pronouns

Main phone\*       Mobile

Email       Date of Birth\*      

Address\*       Town\*

Postcode\*

**Contact method**

Please complete this section carefully. Supporting you to access the right services is very important to us but it isn't always easy to make contact, so listing as many contact options as possible will help us to help you more quickly.

How would you like us to contact you? Main phone  Mobile  Email

Is it OK for us to leave a message on your mobile? Yes  No

What day(s) and or time(s)would you prefer us to contact you? (Monday - Sunday)

**GP details**

GP Surgery\* (Please state unknown if you do not have this information)

**School details**

**Are you currently in education?**

Yes, in school/ college

Yes in school/ college, but partially attending

Yes, in home schooling

No

Name of school (if applicable)

**Emergency contact information**

Name       Contact number      Relationship to you      

My emergency contact has given their consent to share this information Yes

**Further information**

Our Community Counselling service provides free counselling for children and young people in Hertfordshire. Our service is for ages 5 to 19 and is available to those registered with a Hertfordshire GP.

Counselling can be one-to-one or in a group, and sessions can take place in-person or online. The best option for you will be decided together at the initial appointment.

**Please tell us your reasons for seeking counselling and what you need help with?\***

**Have you referred or been referred to any other services recently?**

**Are there any other professionals or organisations involved in supporting you at present?**

**Is there any additional information we need to know for you to access our services? e.g. language, disability, access to digital devices? \***

**How did you hear about us? \***

GP

School/ Sixth Form or College

Promotional event

Social media

CAMHS

Friend or family

Our website

Other

**Details of referrer (if completing the form on behalf of someone else)**

Name of referrer       Organisation

Email       Tel number

The child/ young person has given verbal and/or written consent for me to make this referral.

Yes  No

**Equal Opportunities and Disability Monitoring**

**Age Group**

5-9  10-14  15-19  20-25

**Gender**

Male  Female  Transgender (male to female)  Transgender (female to male)  Questioning (undecided)  Non-binary  Prefer not to say  Other gender description (please specify)

**Sexual orientation**

Heterosexual  Gay man  Lesbian/ Gay woman  Bisexual  Questioning (undecided)  Prefer not to say  Other sexual orientation description (please specify)

**Religion/ faith**

No religion/ faith

Christian (any denomination)

Buddhist

Hindu

Sikh

Muslim

Jewish

Other

Prefer not to say

**Ethnicity**

White British

Any other White background

Mixed – White and Black African

Any other mixed background

Pakistani

Chinese

Caribbean

Any other Black background

White Irish

Mixed - White and Black African

Mixed - White and Asian

Indian

Bangladeshi

Any other Asian background

African

Any other ethnic group

Prefer not to say

**Housing type**

Private rented

Rough sleeping

Sofa surfing

Temporary accommodation

Living with family

Living with friends

Private owned

University/ College accommodation

Accommodation tied to employment

Supported living

Hotel/ B&B

Housing Association

Please name your Housing Association (if applicable)

Other, not listed

**Caring responsibilities**

Carer of a child (under 18)

Carer of disabled child/ children

Carer of adult family member

None

**Are you a member of Armed Forces (or previous member)?** Yes  No

**Are you a care leaver?** Yes  No

**Data Protection and Confidentiality**

Hertfordshire Mind Network adheres to the Data Protection Act 2018’s principles of good information handling and the EU General Data Protection Regulation 2018.Please indicate below if you consent to us collecting, recording and processing your personal data for the purpose of providing you with support and to ensure your health, safety and wellbeing. We will use your information appropriately and in line with our Privacy Policy which you can see here: [Privacy Policy](https://www.hertsmindnetworkcyp.org/privacy-policy/)

Your details will not be shared with anyone else without your consent. If you have any concerns or questions about how your personal data is collected and used, please ring us on **02037 273600** or email us at [cyp@hertfordshiremind.org](mailto:cyp@hertfordshiremind.org)

Please note that without your consent, you will not be able to submit this form and access Hertfordshire Mind Network’s services.

Where information is given in confidence that Hertfordshire Mind Network believes poses a risk to the client, a risk to other people, a risk to the safety and welfare of a child, or is against the law, we reserve the right to disclose that information to a relevant third party.

**Do you consent to us collecting, recording and processing your personal data for the purpose of providing you with support and to ensure your health, safety and wellbeing? \***

Yes  No

**Where to send your completed form**

Please email your completed form to [cyp@hertsmindnetwork.org](mailto:cyp@hertsmindnetwork.org) If you have any questions or would like help filling in this form, please call us on **0208 189 8400**