About Children Ltd
Creative Therapy Service

Adult Referral Form

Full Name	
Date of Birth	
Home Address Is it safe to write to you at this address? Y/N	
Contact Number(s) Is it ok to contact you on this number? Y/N	
Email Address Is it ok to contact you on this email? Y/N	
Emergency contact (Name and number)	
GP Address and Telephone Number	

Please give names and contact details of all other professionals that you are involved with

Name	Professional Role	Contact Details

Please give brief details of the reason for your referral. Feel free to attach additional information.

Have you ever used self-harm as way of coping with distressing thoughts or feelings? If yes, please give details.			
Do you currently have any suicidal thoughts? Have you ever struggled with these in the past? If yes, please give details.			
Have you made any plans or attempts to take your own life? Is this something you are currently struggling with? If yes, please give details.			
What are your current coping strategies?			
What do you hope to change through the process of therapy?			
Attendance availability (please tick)		AM	PM
	Monday		
	Tuesday		
	Wednesday		
	Thursday		

☐	By ticking this box, I confirm that I have read and understood About Children's Privacy Notice

PLEASE NOTE WE DO NOT PROVIDE SHORT TERM WORK

Signed _____

Print _____

Please return to : info@aboutchildren.org.uk