Children CBT Referral Form

Please note the age range for children CBT from 8 – 17 years of age

1. Personal details

Name of client :
Address:
Client contact number:
Sex:
Ethnicity:
Religion:
Who does the child lives with?
D.O.B: *
Date of referral:
NI details required *

2. Education details

Name of school:

School contact details:
Head teacher name:
Has there been any special education needs, type of support received? Has their problem affected their education?

3. State of health

Is the child/young person open to CAMHS? Has he/she received a mental health diagnosis:
Other health issues / Disability:
Medication/s taken:
Is the young person known to the Mental Health Service? Is the young person receiving or been referred to any other counselling service?
Safeguarding Issues Please list any risk or safeguarding issues (e.g. self-harm, suicidal acts, child protection concerns)

Please provide name and address of the client GP

4. Other details

Please describe client's current presentation (areas of concern) Please state what could be contributing to the problem? Do you have any goals that you would like the child to work on?
What other agencies are working with the client?
Has the client's parent/career agreed to CBT
Please confirm if you have discussed the referral with the young person
Have you read and discussed the referral to the client or carer? Have they understood the referral: Yes No:
5. Consent Please can this form be signed by the client Date: