Action Deaf Youth

Let's Play and Grow Service

PLAY THERAPY REFERRAL FORM

Action Deaf Youth

Let's Play and Grow!

Families First AWARDS FINALIST

2017 Ni4kids FAMILY AWARDS Winner

professional standards authority accredited register

Name of child:	**M / F**	**D.O.B:**
School:		**Year Group:**
Ethnicity:	**Home Language:**	
Child's level of deafness:		
Child's preferred communication:		
Parent/carer contact details: (Home address, mobile no., email address if possible)		

Background information and reasons for referral: Please include the reasons for the referral and what you think is the cause of this.

What four things do you hope will happen as a result of attending play therapy?	
1.	
2.	
3.	
4.	

Please give details of any other intervention(s) this child has received and when?

Please give details of any diagnosis (e.g. ADHD)**, any medication and/or other medical problems or allergies:**

Please give details of any other agencies involved with the family:

OTHER INFORMATION			
Referred by:	**Parent**	**Teacher**	**Other**
Is this child adopted or in the process of being adopted?		**Is this child fostered?**	
Who has parental responsibility?		**Are all those holding parental responsibility in agreement with therapy? Yes No**	
Is there an Early Help Notification Form currently open on this child? (If yes please attach a copy)		**Yes**	**No**

Signature of Referrer:	**Date:**