BRADFORD RELATE INTER-AGENCY REFERRAL FORM

Please complete this form by giving as much detail as possible to help us in our assessment of the clients you are referring. This saves time for us and you as we will need to come back to you for any information that is not on the form. Thank you.

Your details

Your agency	
Your name	
Your role	
Your telephone number	
Your email address	
Your postal address	
Date	

Details of referral

Please tick relevant answers

Type of counselling required: **Young persons** ☐ **Family** ☐ **Relationship** ☐ **Individual** ☐ **Caring and Sharing** ☐ **IAPT Couple Therapy for Depression** ☐ **Sex Therapy** ☐ **Prostate Cancer – emotional/relationship/psychosexual support** ☐

Have the clients been referred to Relate Bradford before: **Yes** ☐ **No** ☐

If so please give details:

If you are referring from the local authority is involvement: **Voluntary** ☐ **Compulsory** ☐

Are the clients aware of this referral: **Yes** ☐ **No** ☐

What are the clients' views of the referral:

Have the clients consented to the sharing of information between our organisations:

Yes ☐ **No** ☐

Are there any court proceedings current or pending: **Yes** ☐ **No** ☐

If yes please give details (**please give details of any injunctions that are in place**):

Details of the client(s) you are referring – *adult clients*

Please include the details for parents/carers in this section as they will be asked to attend an assessment if the referral is for young persons counselling and the young person is under 16.

	Adult client 1	Partner if attending
Name		
Date of birth		
Gender		
Address		
Health centre		
Tel Numbers	Home: Work: Mobile:	Home: Work: Mobile:

Does the client(s) have any special needs or disabilities: Yes ☐ No ☐

Does the client(s) have any language needs: Yes ☐ No ☐

If yes please give details:

Contact restrictions (please tick all that apply)

☐ Ok to say Relate calling
☐ Ok to write to address

☐ Do **not** to write to address
☐ Partner is not aware of contact
☐ Under 16 – Parents aware of contact

Preferred Time(s) for an appointment (please tick all that apply)

☐ Morning
☐ Afternoon
☐ Evening

☐ Monday
☐ Tuesday
☐ Wednesday
☐ Thursday
☐ Friday

Extra information – specific times?

Details of the clients *children*

Are any of the children on the child protection register? **Yes** ☐ **No** ☐

If so please provide details:

Is there a CAF in place? **Yes** ☐ **No** ☐

If so please provide details:

	Child 1	**Child 2**	**Child 3**
Name			
Date of birth			
Address			
Health Centre			
Gender			
Carers			
Birth parents			
School			

	Child 4	**Child 5**	**Child 6**
Name			
Date of birth			
Address			
Health Centre			
Gender			
Carers			
Birth parents			
School			

Other agencies

Are any other agencies involved with the client(s)? **Yes** ☐ **No** ☐

If so please provide as much detail as possible about who is involved and what their involvement is:

Payment

We do not ask clients who live in the Bradford District to contribute payment toward sessions for any of the following services:

- Caring and Sharing
- Prostate Cancer – emotional/relationship/psychosexual support
- Young person's counselling
- IAPT Couple Therapy For Depression
- Referrals received from a statutory organisation for Relationship Counselling or Sex Therapy

Adult clients will be asked if they are able to contribute payment toward:

- Family counselling
- Referrals received from non-statutory organisations for Relationship Counselling or Sex Therapy

Clients are only asked to contribute what they can comfortably afford toward sessions and this can be renegotiated if their financial circumstances change. Clients are able to access the service for free if they really are unable to contribute anything toward the cost of sessions.

Reasons for referral

What has prompted you to make this referral now?

What does the family hope to achieve with this referral?

What do you hope to achieve with this referral?

Family Tree

Issues affecting the family (please provide as much detail as possible)

	Past	Current
Parental drug/alcohol abuse		
Child drug/alcohol abuse		
Mental health issues adult/child		
Physical health issues adult/child		
Domestic violence		
Physical abuse		
Sexual abuse		
Education issues		
Child behavioural issues		
Parenting skills		
Other (please specify)		

Thank you for taking the time to fill out this form.

Please return the form by post to Relate Bradford, First floor, Bradford Trident Business Centre, 11 Edward Street, BD4 7BH or by fax to 01274 729844. If you have any queries please do not hesitate to contact us on 01274 726096.

PLEASE NOTE WE WILL CONTACT YOU TO CONFIRM WE HAVE RECEIVED YOUR FORM. IF YOU HAVE NOT HEARD FROM US WITHIN 7 DAYS PLEASE CONTACT US.