

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

Details of referral

Type of counselling required: Young persons /family / relationship / individual

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

If yes please give details:

If you are referring from the local authority is the client's 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:

Details of the client(s) you are referring

| | Client 1 | Partner if attending |
|---------------|---------------------------|---------------------------|
| Name | <input type="text"/> | <input type="text"/> |
| Date of birth | <input type="text"/> | <input type="text"/> |
| Address | <input type="text"/> | <input type="text"/> |
| Health centre | <input type="text"/> | <input type="text"/> |
| Tel Numbers | Home: Work: Mobile: | Home: Work: Mobile: |

Does the client(s) have any special needs or disabilities: 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

| | Child 1 | Child 2 | Child 3 |
|---------------|----------------------|----------------------|----------------------|
| Name | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Address | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date of birth | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Gender | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Carers | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Birth parents | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| School | <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | Child 4 | Child 5 | Child 6 |
|---------------|----------------------|----------------------|----------------------|
| Name | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Address | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date of birth | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Gender | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Carers | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Birth parents | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| School | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Are any of the children on the child protection register?

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

| | 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) | | |

Any other information you think may be useful:

Please return the form by post to Relate Bradford, 7th Floor City House, 21-27 Cheapside, Bradford, BD1 4HR. 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 48 HOURS PLEASE CONTACT US.