AURORA
Wellbeing Services

Children & Family Service referral			
Date of Referral:			
Referrer Information			
Referrer Name		**Referring Organisation Address**	
Referrer Role		**Referring Organisation Postcode**	
Referrer Telephone No.		**Referrer Email Address**	
Client (Child or Young Person) GP Information			
GP Name (if different from above)		**GP Address**	
GP Surgery		**GP Telephone No.**	
Client (Child or Young Person) Information			
Name		**Date of Birth**	
Address 1 Address 2 Town/City		**Postcode**	
Contact No.		**Able to leave message?**	
Nationality		**Language**	
Gender		**School/Collage**	
Ethnicity		**Sexual orientation**	
Parental/Carers Information			
Name		**Date of Birth**	
Address (if different from above)		**Postcode**	
Mobile No.		**Name of emergency contact**	
Home No.		**No. of emergency contact**	
Email Address		**Relationship with child**	
Reason for referral (please tick)			
1 to 1 Play therapist support		Family sessions	
1 to 1 Young Persons counselling support		Group sessions	
Other……			

Further information (including any additional needs)	
Is the child or young person a risk to themselves or others? (if yes please specify)	
Is the child or young person engaged with/referred to any other Mental Health Services? (if yes please specify)	
By ticking the box you consent to Aurora recording the above details ☐ *Information provided above will be included on the above child's file, that will be securely kept at Aurora*	

Please return the form either via email to emma.walker@aurorawellbeieng.org.uk or by post to The Aurora Wellbeing Centre, The Old Library, Memorial Avenue, Worksop, S802BJ