



Play Therapy Referral Form

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| Child's Name | | Parent's Names: | |
| Contact Details for Parents | | | |
| Age D.O.B. | | Male / Female | |
| School and/or Class | | Teacher's name | |
| Ethnic Origin | | 1 st Language Level of Proficiency in English | |
| Family Details: | | | |
| Referred by: | | Professional relationship to child/family | How long will you hold this role? |
| Contact Details: Email: | | | |

Family Background and/or Issues (Anything you think the Play Therapist should be aware of)
Did you discuss your concerns with the family? Have you received consent to share information and to make this referral?

What are the reasons for concern (include duration of problems)?

Have you any ideas about contributory, exacerbating or alleviating circumstances?

Any Other Relevant Information (e.g. recent significant events, medical, other services involved (current or past), child's talents & interests, supports available)



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How would you know things were getting better? What changes would you like to see? What might the child do differently that would alleviate your concerns?

- 1.
- 2.
- 3.

The referral must be signed by both parents.

Signature Parent 1: _____

Signature Parent 2: _____

Please return to Mohill Family Support Centre, Canon Donohoe hall, Main Street, Mohill Co Leitrim
or email coordinator@mohillfsc.info