Play Therapy Referral Form

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		1st Language Level of Proficiency in English	
Family Details:			
Referred by: Contact Details: Email:		Professional relationship to child/family	How long will you hold this role?

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: _____

There will be a minimum of €20 per session with the counsellor as we are only partially funded for the service and if clients can contribute more this would be much appreciated as this helps for the service to continue. We thankyou in advance for your understanding any issues please contact Angie the Manager

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