** Fairfield Primary School**

**Referral for Pupil Counselling Form**

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| --- | --- | --- | --- | --- | --- |
| Name of pupil | | | | Year/Class | |
| DOB | Address:  Post code: | | | | |
| Referred by: | | | Date of referral: | | |
| Consent for referral given by parent /carer (please tick box) | YES | | NO | | |
| Outline of concern/issue | | | | | |
|  | | | | | |
| For Counsellor use only | | | | | |
| Referral approved (Please tick box) | | YES | | NO | |
| Timescale for counselling session if not immediate | |  | | | |
| Date of initial counselling session | |  | | | |
| Contact made with parent/carer to discuss referral | | YES | | | NO |
| Date contact made | | | | | Time |