** Fairfield Primary School**

 **Referral for Pupil Counselling Form**

|  |  |
| --- | --- |
| 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 |