HOLDING SPACE REFERRAL FORM – CHILD/YOUNG ADULT

Please return via email: contact@holdingspace.org.uk

NAME OF CHILD/YOUNG ADULT	
GENDER	Male/Female/non binary/prefer not to say
ADDRESS	
TELEPHONE NUMBER (aged over 18) (mobile)	
DATE OF BIRTH	
EMAIL ADDRESS	
NAME OF PARENT/GUARDIAN (if under 18)	
RELATIONSHIP TO CHILD	
ADDRESS (If different)	
TELEPHONE NUMBER	
NAME AND ADDRESS OF GP	
REASON FOR REFERRAL (please give brief background)	
IS CHILD/YOUNG PERSON AWARE OF REFERRAL?	**YES /NO (WRIITEN OR VERBAL CONSENT)**
FAMILY NETWORK	
OTHER SUPPORT BEING RECEIVED? Please give details and names/contact details (CAMHs/ Social worker etc)	
NAME OF REFERRER	
RELATIONSHIP	
ORGANISATION/SCHOOL	
ADDRESS	
TELEPHONE NUMBER	
EMAIL ADDRESS	
DATE OF REFERRAL	

FOR HOLDING SPACE

DATE REFERRAL RECEIVED	
CONTACT MADE WITH CLIENT (date/ details)	
REFERRAL TO THERAPIST (name and date)	

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Data protection & Privacy: Holding Space will only use this data as part of the referral process and details will only be passed to members of Holding Space team of therapists. We will maintain your privacy and confidentiality in line with our Privacy Policy. A copy is available on our website or on request