TUSLA An Ghníomhaireacht um Leanaí agus an Teaghlach Child and Family Agency

Play Therapy Referral Form: Ballymote FRC

Please complete this referral and return it by email to the Coordinator at coordinatorballymotefrc@gmail.com for the attention of The Play Therapist or by post to The Play Therapist, Ballymote Family Resource Centre, Wolfe Tone Street, Ballymote, Co. Sligo.

Following receipt of the referral, the Play Therapist will contact you.

Where did you hear about the play therapy service?	Todays Date:
Name of Referrer (specify status)	
Name of Child/Young Person:	Date of Birth:
Name of Parent(s):	Address: Contact No:
What school does he/she attend:	Class and Teacher's Name:
Any diagnosis (e.g. ADHD)/medical problems or allergies and any current medication:	Any other agency your child has been getting help from at present or in the recent past:
Parental consent of both parents:	Child/young person consent √

Both parents must consent.: Signed:_______________________________________ Signed:_______________________________________ Date:____	☐

How do you think Play Therapy would be of help to your child. Please give as much detail as you can.

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Any other information you want to provide:

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For Office Use Only	
Parent interview date:	**Referrer interview date:**
Child/Young person Interview/Start date:	**School interview date (if any):**