Out of the Box
Play and Creative Arts Therapy

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Name of child:	**M/F**	**D.O.B:**
Year Group:	**Class:**	**School:**
Ethnicity:	**Home Language:**	

Background information and reasons for referral: Please include the reasons for the referral and what you think is the cause of this.

What four things do you hope will happen as a result of seeing the Play Therapist?	
1.	
2.	
3.	
4.	

Please give details of any other intervention this child has received and when?

Please give details of any diagnosis (e.g. ADHD), **any medication and/or other medical problems or allergies:**

Please give details of any other agencies involved with this family:

Is there anything that has been particularly difficult for the child?				
Tick as appropriate:	**School action**	**School action plus**	**Statement**	**SEN**

Is this child adopted or in the process of adoption?	**Is this child Fostered?**
Who has parental responsibility?	**Are all those holding parental responsibility in agreement with therapy? Yes No**

Is there a CAF currently open on this child? (If yes please attach a copy)	**Yes**	**No**

Referred by:	**Teacher**	**Parent/carer**	**Social worker**	**Other**

Signature of Referrer:		**Date:**	
Parent Interview Date:	**SENCO Meeting dates:**	**Referrer/Teacher Meeting Dates:**	**Play Therapists Name:**

Parent consent:	**Yes**	**No**	**Child consent:**	**Yes**	**No**