MIDLANDS ULTRASOUND & MEDICAL SERVICES
M.U.M.S

Address: 1 Park Avenue, Solihull, West Midlands, B91 3EJ
Tel: 0121 704 2669, **Website:** mums.me.uk

YOUNG PERSON PSYCHOTHERAPY AND COUNSELLING

Date: _____

Name of client: _____ Date of birth: _____

Address: _____

_____

Email: _____

Telephone: _____

Name of GP: _____

GP Address: _____

_____

GP Telephone: _____

Next of kin in case of emergencies

Name: _____

Telephone: _____

Are you currently on any medications?

_____

_____

_____

Parent/Guardian, Details if client is under 16 years:

Name: _____

Telephone: _____

Email: _____

Referral

Initials of Child:	
Date of Birth	
Year Group	
Ethnic Origin	
Any diagnosis e.g. ADHD etc.	
Any medication	
Any allergies	
Is your child under any other services providing them support, and if so what is this for?	
Is the child adopted or under foster care?	

Reasons for Referral

What are the reasons for concern?

_____

_____

_____

_____

_____

_____

What do you think is the cause of this?

_____

_____

_____

_____

_____

_____

What four things do you hope will happen as a result of your child seeing the therapist?

1) _____

_____

2) _____

_____

3) _____

_____

4) _____

_____

Child Likes

_____

_____

_____

_____

_____

_____

Child Dislikes

_____

_____

_____

_____

_____

_____

Any other comments that you feel I would need to know?

_____

_____

_____

_____

_____

_____

Parental / Guardian Consent

I give consent for _____ (first name only)

to attend Children's Therapy sessions with certified Therapist Hema Patel.

I am also happy to meet to discuss my concerns and can be contacted on:

Mobile and or email: _____

Note: assessment data will be recorded for the purposes of the evaluation of the effectiveness of therapy. Data may also be used for research purposes but the identity of you and your child will not be disclosed or recorded in the research database. I agree to the use of this data for research purposes and the therapy sessions.

Name: _____ (parent or guardian)

Signed: _____ (parent or guardian)

Date: _____