Wiltshire Family Counselling Trust

Self-referral Form

FCTW accepts self- referrals from parents and families where a child or young person has a significant problem which is interfering with their functioning and/or causing emotional and behavioural difficulties such as mood disorder, obsessive/ compulsive behaviours, generalized and specific anxiety, panic attacks, uncharacteristic displays of anger and aggression, receiving or contributing to bullying behaviour. Referrals of Looked-After children cannot be accepted by FCT as very specific criteria have to be met to satisfy local authorities in whose care they are.

FCTW do not accept children and young people with more severe mental health problems such as psychosis, severe self-harming, eating-disorders or highly risky or suicidal behaviour and we do not offer a crisis or emergency service. We do not see children or young people who are currently being seen by CAMHS (Child and Adolescent Mental Health Services). We can see some young people who may have an existing diagnosis eg autism if there is another problem.

If your referral is accepted, we offer a choice of up to three possible therapists for your child for up to six counselling sessions in any one financial year. Financial contributions towards therapy is on a sliding scale and assessed on the basis of household income as follows. If your child receives pupil premium, school may be able to help with funding.

Please indicate your income.

Up to £25,000 pa including benefits: (you pay £5 per session) Yes/No/Unknown

£25,000 - £35,000 pa including benefits (you pay £20 per session) Yes/No/Unknown

Over £35,000 pa including benefits (you pay £45 per session) Yes/No/Unknown

Child receives pupil premium at school Yes/No/Unknown

Date of completing this form	
Full name of child or young person for whom help is sought	
Child's date of birth	
Child's home address	
Address of school/college	

Your full name	
Your address if different from your child's address.	
E mail address	
Phone number	
Relationship to child	
Do you have parental responsibility? If no, who else has this?	Yes/No
Parent/s names if not given above	
Parent/s address if not given above	
Name, address and telephone number of GP	
Does the GP/school know about this referral?	Yes/No
Information about what help you are seeking for your child	
Please describe your concerns.	
How long have these concerns been present?	
What effect are these concerns having on your child's home, social and school life?	
What have you already tried?	
Has your child had or is having any other help with these difficulties? If so from whom?	
What help are you and your child / young person hoping for?	
Have you talked to your child/young person about this referral?	
Are they willing to see a therapist?	
Are there any other services involved in supporting your child or family, if so who? Eg GP, school, social worker.	

Do you give consent for us to contact other agencies? We would talk this over with you first.	Yes/No
Is there any current police or court involvement with you or your family?	
Are there any safeguarding concerns or child protection involvement for your child or family? Please provide contact details.	

Thank you for completing this form. Please mark the envelope ‘Private and Confidential’ and send it to:

FCT Wiltshire

Cyndy Walker, Family Liaison Officer

c/o The Practice Rooms

7A Catherine St

Salisbury

Wiltshire SP1 2DF