Child and Adolescent Creative Therapy Centre

To be completed by the referrer seeking to refer a child for creative therapy

Details of child being referred for creative therapy:	
Name:	
Date of birth:	
Address:	
Phone: E-mail:	

Referring Agency details:	
Name of referrer*:	
Position:	
Keyworker name *(if different):*	
Organisation:	
Contact number(s):	
Email:	
How long have you engaged with the child being referred?	

To be completed by referrer

Risk assessment			Please Give Details
1. Do you consider that this child • Has the capacity to engage fully in creative therapy:	Yes ☐	No ☐	
• Would benefit from one to one creative therapy work:	Yes ☐	No ☐	
2. Does the child understand what creative therapy entails?	Yes ☐	No ☐	
• Has s/he received an information leaflet:	Yes ☐	No ☐	
3. Does the child being referred have any mobility issues?	Yes ☐	No ☐	
4. Are you aware of any areas of risk that we may need to be aware of in considering this child for creative therapy?	Yes ☐	No ☐	

Please include any additional relevant details:

Signature of Referrer _____ **Date:_____**

Office use only:

Date of receipt: ___/___/_____ Referrer/service user contacted on: ___/___/_____

Assessment offered on: ___/___/_____ Initial appointment offered on: ___/___/_____

Please return this document along with the Creative therapy Referral Form and consent forms to First Fortnight at :

9 Berkeley Street Dublin 7 D07 HNF4. Once sent please notify us of the referral via email at: cactus@firstfortnight.ie.