Family Referral Form

# Referral Guidelines

1. Please complete this form and return it to the coordinator via post to ACBS C/O The ARCHIE Foundation, Royal Aberdeen Childrens Hospital, Westburn Drive, Aberdeen, AB25 2ZG or email your completed form to acbs.grampian@archie.org
2. Please provide us with as much information as possible.
3. Once a referral form is received, we will contact as soon as possible and no later than 10 working days. If you have not been contacted within 10 working days, please contact the coordinator
4. The Coordinator can be contact via telephone 01224 554152 or email acbs.grampian@archie.org (part time hours)

# Parent/Carer Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Parent/Carer: | |  | Date: |  |
| Address: | |  | Email: |  |
|  |  | | Telephone: |  |
|  |  | | Mobile |  |
|  |  | |  |  |

# Child 1 Details

|  |  |  |
| --- | --- | --- |
| Name: | |  |
| Age and DOB: | |  |
| School: |  | |
| Relationship to referrer: |  | |
| Medical Practice: |  | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Any siblings not referred:  **Child 2 Details**   |  |  |  | | --- | --- | --- | | Name: | |  | | Age and DOB: | |  | | School: |  | | | Relationship to referrer: |  | | | Medical Practice: |  | |  |  | | --- | |  |   **Child 3 Details**   |  |  |  | | --- | --- | --- | | Name: | |  | | Age and DOB: | |  | | School: |  | | | Relationship to referrer: |  | | | Medical Practice: |  | |  |  | | --- | |  |   **Child 4 Details**   |  |  |  | | --- | --- | --- | | Name: | |  | | Age and DOB: | |  | | School: |  | | | Relationship to referrer: |  | | | Medical Practice: |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Bereavement Information  |  |  |  | | --- | --- | --- | | Bereavement: | |  | |  | |  | | Date of Bereavement: |  | | | Reason for Referral: | . | | |  |  | | | |  |  Additional Information  |  |  |  | | --- | --- | --- | | Any Additional Needs: | |  | |  | |  | | Support services already in place i.e. SW,CLAN etc. | . | | | How did you hear about ACBS?: |  | | | Is the child/ren aware of the referral: | yes | |  |  |  | | --- | --- | | What bereavement support are you looking for?: |  |   Would you like to be added to our mailing list? Yes  No   |  |  | | --- | --- | | Any additional information: |  | |

# Office use only

|  |  |  |  |
| --- | --- | --- | --- |
| Date Received: |  | Referral Code |  |
| Date pack sent |  | Responder required? | Yes  No |
| Responder Name: |  | Responder Contact Date: |  |

|  |  |
| --- | --- |
| Agreed action |  |
| Books and resources sent |  |

# Responder and Office updates

|  |  |  |
| --- | --- | --- |
| **Date** | **Name** | **Action/Update** |
|  |  | . |
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**Please note that unless otherwise directed by the family point of contact, this form will be retained for a period of twelve months after your involvement with us is complete. Similarly your details will remain on our parents database for the same time frame. If you have opted to be included on our mailing list, you will remain on that list until you advise us that you wish to be removed from the mailing list.**