The Referrer

|  |  |
| --- | --- |
| Date of Referral |  |
| Name of Referrer |  |
| Role |  |
| Telephone of Referrer |  |
| Email of Referrer |  |
| Contact address of Referrer |  |

The Participant

|  |  |
| --- | --- |
| Name of Course Participant |  |
| Telephone/mobile |  |
| Email |  |
| Address |  |

The Family

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Names of family members living at home or elsewhere | Relationship | DOB | Crèche required yes/no | Any known medical diagnosis/allergies |
|  |  |  |  |  |
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| --- | --- |
| What are the reasons for the referral or booking? |  |
| Are you/the parent/carer aware that the course runs for 10 weeks and involves home practice? |  |
| What are the your/parent/carers best hopes for attending the ‘Stressbusting for parents/carers’ course? |  |
| Please state any known / significant historical and current physical and mental medical diagnosis/details |  |

**Guidance Notes**

Please consider your referral very carefully before sending through.

We will consider all referrals but would invite the following criteria:

* Individuals who are free of any **current** life crisis significantly impacting mental health.
* Individuals who have been identified as, on low income, who would not normally afford these courses or be able to access this kind of group
* Individuals who have been identified as experiencing some suffering and challenge in life between parent/child relationships
* Individuals who are experiencing high levels of parental stress
* Parents/carers who are able to commit to daily practice
* Parents/carers who are able to commit to every session
* Individuals from a BME background

