MUSIC THERAPY BEDFORDSHIRE
REFERRAL FORM
Children and Young People

First Name | Surname

Date of Birth | Gender

First Language | Ethnic Category

Parent/Carer Name 1 | 2

Relationship to Child 1 | 2

Parent/Carer email address 1 | 2

Phone: Landline | Mobile 1 | Mobile 2

Address Line 1

Address Line 2

Address Line 3

Postcode

School/Early Years setting currently attended

School/Early Years Phone

School/Early Years contact person

N/C Year Group

Child's method of communication, e.g. verbal, non-verbal, signing etc

Does the child have a special educational need? ◯ Yes ◯ No

If 'Yes', please give details

Involvement of Other Agencies

Please give names and contact details of other professionals involved, e.g. Social Worker, CAMH workers, Educational Psychologist, Paediatrician, Other Therapists etc

Name | Profession | Phone

Email

Additional information regarding involvement

Name | Profession | Phone

Email

Additional information regarding involvment

Name | Profession | Phone

Email

Additional information regarding involvement

Name | Profession | Phone

Email

Additional information regarding involvement

Name | Profession | Phone

Email

Additional information regarding involvement

Reason for Referral

Please give details of the child's difficulties and/or strengths in the following areas:

Behaviour
Include, for example: aggression, social withdrawal, selective communication, rigid behaviour etc

Mental/Emotional Health
Include, for example: depressed behaviour, anxieties, phobias, self-harm, eating disorders, OCD etc

Medical and/or Physical Health
Include, for example, physical disabilities, sensory difficulties, mobility issues etc

Other

When did these difficulties become apparent?

What gains do you expect from a course of Music Therapy

What other treatments or interventions have already been explored? e.g. counselling, behaviour support, SALT, physiotherapy

Does the child pose a risk to themself or others in their current environment? ◯ Yes ◯ No

If 'Yes', please give details

Has a risk assessment been carried out? ◯ Yes ◯ No

If 'Yes', please attach a copy. (We cannot start work without this)

Does the child have any links with a hospice? ◯ Yes ◯ No If 'Yes', please state which one

Does the child have an EHCP? ◯ Yes ◯ No

If 'Yes', please state the date of the original EHCP and please attach a copy

Please state the intended source of funding for any Music Therapy offered

Any other information you would like to give relating to this referral

This referral has been made with the support of the child's Parent/Guardian ◯ Yes ◯ No

Name of Referrer

Job Title

School

Email address

Phone

Date

I am attaching a copy of the EHCP ◯ Yes ◯ No

I am attaching a copy of the risk assessment ◯ Yes ◯ No

Please email this completed form along with any other documents to:
anna.jacobs@musictherapybedfordshire.co.uk
For further information or postal address, please contact
Anna Jacobs
Manager, Music Therapy Bedfordshire
07850 914130
www.musictherapybedfordshire.co.uk

DATA PROTECTION ACT 1998: ASSURANCE OF FAIR PROCESSING
Please note that the details supplied regarding this pupil will be held in a pupil file and / or computerised records. These details may be disclosed to other agencies directly involved in the support of the pupil, for example Health, Social Services and Education Services. They will not be divulged to any other individuals or organisations for any other purposes.
MTB – December 2023