



# SYMBOL FAMILY SUPPORT SERVICES LTD REFERRAL FORM

Please complete this form as fully as possible and return to Symbol Head Office by post or via fax on 01795 844414.

**Please note the instructing authority/solicitor has direct responsibility to arrange payment with our terms of payment.**

## DETAILS OF INSTRUCTING BODY

Solicitor / Local Authority Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Tel No: \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

Fax No: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Purchase Order / \_\_\_\_\_

Reference No: \_\_\_\_\_

## DETAILS OF FAMILY

Parent(s) Name(s): \_\_\_\_\_

Parent(s) D.o.B: \_\_\_\_\_

No of Children: \_\_\_\_\_ Ages of Children: \_\_\_\_\_

Status of Children:

Unborn Due Date: \_\_\_\_\_

With parent

With family member \* Please specify: \_\_\_\_\_

In Local Authority care \* Placement Date: \_\_\_\_\_

\* Please indicate weekly contact schedule: \_\_\_\_\_

Please indicate number of adults expected to be included in the assessment \_\_\_\_\_

Please indicate number of children expected to be included in the assessment \_\_\_\_\_

**INFORMATION CONCERNING THE PARENTS**

Has parent been diagnosed with a learning disability? Yes / No

Please provide WAIS Scores

Verbal \_\_\_\_\_

Performance \_\_\_\_\_

Full Score \_\_\_\_\_

Has parent been diagnosed with mental health problems? Yes / No

Please provide specific information

Does parent have any issues with alcohol or substance abuse? Yes / No

Please provide specific information

Does parent have a criminal record (spent or unspent)? Yes / No

Please provide specific information

Please outline the main concerns surrounding this family:

## ASSESSMENT SPECIFIC INFORMATION

Has parent had any previous assessments?

Yes / No

Please indicate what type and date of:

Please indicate the volume of Documents for this family: \_\_\_\_\_

At this time, what type of Assessment do you consider you require?  
(More than one may be indicated)

- |  |  |
|--|--|
| <input type="checkbox"/> Document Review         | <input type="checkbox"/> Cognitive     |
| <input type="checkbox"/> Preliminary             | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Community               |  |
| <input type="checkbox"/> Residential Preliminary |  |

Please refer to our Brochure for full details of our assessments.

Please indicate the desired filing date: \* \_\_\_\_\_

\* Filing date will be 6-8 weeks from receipt of letter of instruction and will be confirmed at this time

Please advise dates of Court Hearings: \* \_\_\_\_\_

\* Members of the Assessment team are not available for Court attendance unless requested in writing

Please provide any additional information to help us process your referral