

Rutherglen High School Counselling Service

Hello,

If you are experiencing difficulties at the moment please complete this form and I will contact you as soon as possible. If it is a matter of urgency and you cannot wait for my next appointment please speak to your Pupil Support Teacher.

Alison (School Counsellor)

Name:

Year group:

Age:

Gender: Male/Female/ No specific Gender/ Prefer not to say

Pupil Support Teacher _____

Please tick any of the following difficulties that applies to you.

Anxiety		Depression	
Family Difficulties		Relationship/Friendship Difficulties	
School- Related Difficulties		Exam Stress	
Bullying		Academic Difficulties	
Self-image/Confidence		Eating Disorder	
Behaviour Related Difficulties		Anger	
Bereavement, grief and loss		Sexuality	
Drug/Alcohol Difficulties		Self-harm	
Suicidal thoughts		Other	

Please give further details about the difficulties you are experiencing

What change are hoping counselling can help you with?

Have you received counselling before? Yes/No

Are your parents/carers aware of you have requested counselling? Yes/No

I want my parents to know when I am offered counselling Yes/No

Signed _____ Date _____

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Pupil Support Administration

To be completed by PUPIL SUPPORT TEACHER

Pupil Referral	Self-referred	
	Referred by PST	
	Referred by DHT	
ADSN	Yes / No / Specify	
SIMD	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	
Child Protection Register	Yes / No	
Care Experienced/or LA	Yes / No	
CAMHS Referral	Yes / No	
Other Service	Ed. Psych/ JAT/ None/ Other please specify	
Any other relevant information		

PST/DHT signature _____

Date _____

Pupil informed of YPCS Confidentiality Policy and CTSS (SLC) Privacy Notice and consent given _____ Date _____