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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Young Person (YP)** | |  | | | | | | **I identify my gender as:** | Male  Female  Other  Prefer not to say |
| **Date of Birth** |  | | **Age** |  | **Year group** | |  |
| **First Language** |  | | | | **Ethnicity** | |  | | |
| **NHS number** (you can find this on letters from your GP/NHS health services.  If you can’t find this number, please don’t let this stop you asking for help. | | | | | |  | | | |
| **Phone Number:** | | | **Email Address:** | | | | | | |
| **Name of GP**  **Phone Number** | | | **GP Address:**  **Consent to inform GP of referral to our service:** Yes  No | | | | | | |
| **Have you discussed your interest in this service with your parent/ carer?** | | | Yes No | | | | | | |
| **Would you like your parent/ carer to participate in the sessions?** | | | Yes No | | | | | | |
| **Parent name and contact details** (if you are 15 or under we will need to inform your parents of the referral in writing) | | | **Name:**  **Phone number:**  **Email address:** | | | | | | |
| **Consent for sessions to be conducted via Skype/FaceTime/WhatsApp video?** | | | Yes  No | | | | | | |
| **Which intervention do you feel would be most appropriate for you?** | | | **Anxiety/Worry**  **Low Mood** | | | | | | |
| **Have you tried any other services?**  No  Yes  **If yes please specify**………………………………………………… | | | | | **Was this helpful?** Yes  No  **If not, please state why** | | | | |

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| **Tell us a little about the difficulties you are experiencing.** You don’t need to provide a lot of detail (this form will be seen by your school’s mental health/wellbeing team) but please make sure you include the following:  How long has this been going on? What impact is it having on your everyday life? |
| **What have you already tried to help with these difficulties?** |
| **Are there any other things you think it would be helpful for us to know?** (e.g. parental relationship difficulties, additional learning needs, recent bereavements or other changes in circumstances) |
| **Parents, please ensure that this referral has been discussed with your child**  **Completed by (name): …………………………………………. Signature: …………………………….. Date: ……………………..** |

**Please return this form to your tutor, mental health lead or SENCO**

**TO BE COMPLETED BY SCHOOL**

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| **In addition to the information provided by the young person/parent, please provide your view of the difficulties the young person is experiencing, including the impact the issue is having on their life in the school setting:** |
| **As a school, what have you already tried to help with these difficulties? Please include referrals that have been made and any practical measures that have been implemented to support the young person (timetabling, reduced workload, facilitation of increased peer support/interaction, anti-bullying measures, etc).** |
| **Please let us know about any circumstances you are aware of that might have an impact on and/or inform our intervention with this young person and/or their family.** |
| **Please let us know if there are any safeguarding concerns and whether the family has been referred to social services.** |
| **Source of referral: Self (young person self-identified)  Parent  Professional identified YP** |
| **Please ensure that this referral has been discussed with the YP**  **Completed by (name): …………………………………………. Signature: …………………………….. Date: ……………………..** |

**Please return completed form to**

[**SOUTHFIELDSTRAILBLAZERMHST@swlstg-tr.nhs.uk**](mailto:SOUTHFIELDSTRAILBLAZERMHST@swlstg-tr.nhs.uk)