**Referral Form**

|  |  |
| --- | --- |
| Please complete this form in full and return to[**info@syeda.org.uk**](mailto:info@syeda.org.uk) | |
| Young person’s name |  |
| Date of birth |  |
| Year group and school |  |
| NHS number  *NHS numbers can be requested from the GP or by visiting* [*www.nhs.uk/nhs-services/online-services/find-nhs-number*](http://www.nhs.uk/nhs-services/online-services/find-nhs-number) |  |
| GP name and practice  *SYEDA will contact the client’s GP if there are any serious concerns about their mental/physical wellbeing, their consent is requested at the end of this form.* |  |

|  |  |
| --- | --- |
| Home address/s and living arrangements.  *Please give the full address/s and details of occupants.* | Address |
| Occupants |
| Contact number |
| Contact email |
| Have the young person’s carers/ parents have been informed of this intervention? |  |
| Would the young person’s carers/parents would like a phone call from the therapist?    If yes, please provide a contact number. |  |
| Has this young person received support from other mental health services in the past such as CAMHS?    *If yes, please give details of the name of the organisation and dates.* |  |
| Is this young person currently working with any other mental health services?  *If yes, please state the name of the organisation.* |  |
| Has the young person had any previous incidents of self-harm?  *If yes, please give as much detail as you can.* |  |
| Are there any Safeguarding concerns that you feel are relevant to this referral?  *If yes, please give as much detail as you can.* |  |

|  |  |
| --- | --- |
| Does the young person restrict the amount of food they eat on purpose? |  |
| Do they worry that they have lost control over their eating? |  |
| Do they ever use exercise as a way of coping with difficult thoughts and feelings? |  |
| Do they believe themselves to be overweight when others say they are underweight? |  |
| Do they ever eat large amounts of food to help them cope with difficult thoughts and feelings? |  |
| Would they say that food dominates their life? |  |
| How long have they been experiencing these issues? |  |
| Height and weight: |  |
| Have they lost or gained a stone (14lb/6kg) over the last three months?  If yes, please could you advise how much weight and whether this is a loss or a gain? |  |
| Have they seen their GP about food issues? |  |
| Please use this section to include any other information that you think may be appropriate for the referral. |  |
| GP Consent, by signing this box I understand that SYEDA will contact the GP if there are any serious concerns about mental/physical well being | Signed:  Date: |
| Referral made by  Organisation  Date |  |