**Changing Lives Service Referral Form for Parents/Carers & 16 Years +**

**Complete and return to:** **drcs.adminchanginglives@nhs.net** **or call: 0300 303 4663**

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| **Child or Young Person’s details** |
| Name: |       | Date of Birth (DD/MM/YY): |       |
| Address: |       |
| Postcode: |       | Gender: |       |
| Ethnicity: |       | Length of time in the UK: |       |
| Email Address: |       | [ ]  | I consent to receiving emails |
| Telephone Number: |       | [ ]  | I consent to receiving emails |
| Who is making the referral?*Tick the appropriate boxes.* | [ ]  I am the young person AND I am aged 16 or over[ ]  I agree for my parents/carers to be informed[ ]  I am the parent of the child/young person[ ]  The child/young person has agreed to this referral (The child/young person must consent to the referral) |
| **Parent details** |  |
| Full name of parent(s)/carer(s):  |       |
| Relationship to child: |       |
| Address (including Postcode): |       |
| Telephone Number: |       | [ ]  I consent to voicemails |
| Email Address:  |       | [ ]  I consent to receiving emails |
| **GP details** |
| Name of Doctor/Practice: |       |  |
| Address:  |       |  |
| **School details** |  |  |
| Name of School: |       |  |

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| **Current difficulties** *(Tick all that apply)* |
| Low Mood | [ ]  | Changes in Behaviour | [ ]  |
| Anxiety  | [ ]  | Changes in Appetite/Eating | [ ]  |
| Sleep | [ ]  | Other (please specify) |       |
| **Briefly describe the difficulties at present:** |
| How long have these difficulties been present:       |
| **Describe how these difficulties impact on everyday activities** |
| School: |       |
| Home: |       |
| Family: |       |
| Friendships: |       |
| Other: |       |
| What is your main goal? |  |
|  **Well-being and Safety** *(Please note that if we have concerns regarding well-being and safety we may need to share information with other agencies.)* |
| Has the family had an Early Help Assessment completed in the last 12 months:  | No [ ]  Yes [ ]  |
| Are any other services involved?  | Social Care: [ ]   |  Other: [ ]  If Yes, please detail:       |
| Is there any history of: *(Tick if relevant)* |  Self-harm [ ]  |  Suicidal thoughts [ ]  |
| Any current thoughts or plans of:  |  Self-harm [ ]  |  Suicidal thoughts [ ]  |
|  |  |  |
| I give consent for you to gather information and share it between school and health services. I understand this may include information relating to this referral and issues discussed with the service. Please tick [ ] Name of person providing consent:      |
| Signature:       | Date (DD/MM/YY):       |