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

**Complete and return to:** [**drcs.adminchanginglives@nhs.net**](mailto:drcs.adminchanginglives@nhs.net) **or call: 0300 303 4663**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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: | |  | |  | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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): | | | |