

Sutton Education Wellbeing Service- Application Form

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| **Name of child/ young person** |  | | | **Gender** | Male 🞎  Female 🞎  Other 🞎  Prefer not to say 🞎 |
| **Date of Birth** |  | **Year group** |  |
| **First Language** |  | | | **Ethnicity** |  |
| **NHS number (if known)** |  | | | | |
| **Home address** |  | | | | |
| **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 by letter)** | Name:  Phone number:  Email address: | | | | |
| **If you are 16 or over, are you happy for us to contact your parent/carer if we cannot get hold of you?** | Yes 🞎 No 🞎 | | | | |
| **Day time telephone number (YP or parents number please specify)** |  | | | **Evening telephone**  **number** |  |
| **Email address** |  | | | | |
| **Which intervention do you feel appropriate?** | Anxiety/Worry 🞎 Low Mood 🞎 Sleep Hygiene (3 sessions) 🞎  Boosting Mood (3 sessions) 🞎 | | | | |
| **Have you tried any other services before? If yes please specify** | No 🞎  Yes 🞎 ………………………………………………………………………………………….... | | | | |

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| **Please give a brief description of the difficulties which the young person is experiencing, including the duration and the impact it is having on their everyday life:** |
| **Is there anything which has been tried to help with these difficulties?** |
| **Are there any other things you think it would be helpful to let us know about? (e.g. parental relationship difficulties, recent bereavements or other changes in circumstances)** |
| **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 application form to your Mr Eccles or Pep Nicol at school**