**Children & Young People’s Wellbeing Service Application Form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Child/ young person** |  | | | **Gender** | Male 🞎  Female 🞎 |
| **Date of Birth** |  | **Year group** |  | **Ethnicity** |  |
| **First Language** |  |  |  |  |  |
| **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: | | | | |
| **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 🞎  Boosting Mood During COVID 🞎 | | | | |
| **Have you tried any other services? If yes please specify** | No 🞎  Yes 🞎 ………………………………………………………………………………………….... | | | | |

|  |
| --- |
| **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)** |
| **Completed by (name): …………………………………………. Signature: …………………………….. Date: ……………………..** |

Please return application form to the school SENCo or Mental Health Lead