SELF Referral Form

This referral form is for individuals who wish to self-refer to our Emotional Wellbeing and Mental Health Support Service. It should be completed with as much accuracy as possible and providing all relevant information. As a minimum, we require two alternate forms of contact information and for individuals under the age of 16, details of a parent / carer so that we can request the required consent to work with you. Please note, you may be contacted for further information if we feel this is required and to help facilitate allocation to the most appropriate practitioner.

Completed forms should be emailed to janeharrison@cheviotyouth.co.uk If you require help filling this form out or are a referring professional, please contact us on 07394 562 715 for further assistance or an alternate referral form.

1. Your details (individual being referred)

First Name:	**Surname:**
Date of Birth:	**Current School/college and year or pastoral teacher (if applicable):**
Home Address:	
Telephone No: (Day/home)	**Telephone No: (mobile)**
GLOW Email Address or other email if no GLOW available:	**Date you completed this form:**

2. Parent / carer details *(required for individuals under the age of 16)*

First Name:	**Surname:**
Relationship to referred individual:	
Telephone No: (Day/home)	**Telephone No: (mobile)**
Email Address:	

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3. Reason for referral

4. OFFICAL USE ONLY

Date referral received:	**Date of case allocation:**
Allocated Practitioner:	**Date of archiving:**
Reason for archiving:	

End of form