



CHILDREN & YOUNG PERSONS SELF-REFERRAL FORM

Please return to, Admin, Room 53, Basepoint Business Centre, Aerodrome Road, Gosport, PO13OFQ. Or email to referralsfgwellbeing@solentmind.org.uk

Full Name:			
Are you currently involved with any of the following agencies?:		Please tick:	If the answer is yes to any of these agencies, a formal referral will be required.
	CMHT – Hewat Centre	<input type="checkbox"/>	
	CMHT – Social Work Team	<input type="checkbox"/>	
	Inclusion	<input type="checkbox"/>	
	Probation	<input type="checkbox"/>	
	Adult Services	<input type="checkbox"/>	
	EIP	<input type="checkbox"/>	
	OPMH	<input type="checkbox"/>	
	Elmleigh, Holybank, Antelope	<input type="checkbox"/>	
	Social Services (children/adult)	<input type="checkbox"/>	
CAMHS	<input type="checkbox"/>		

NAME AND TITLE:					
Address:			Tel No:		Gender:
			Message OK:	Yes / No	
			Origin:	Walk In / Phone / Email / Letter / Website	
Postcode:			Email Address:		
Date of Birth:		Current Age:	Referral Type:		
GP Name:			Name of GP Surgery:		
Do you have children?:	Yes / No		Children's Names and DOB:		
Ethnic Background:		Working?	Yes / No	School Attending:	
Next of Kin:		Telephone Number:		Relationship:	

Have you been to see your GP about your mental health?	Yes / No
Have you been prescribed medication?	Yes / No

Form continues overleaf



Do you have any physical health problems which we need to know about?

Do you identify yourself as having a learning disability? If so, please give details:

TO BE FILLED IN BY ASSESMENT TEAM:

Notes on Assessment / Condition / Issues / Triggers / Goals:

Key Worker Allocated: