**Address:**

**Postcode:**

**Confidential CWP Referral Form**

**Gender:**

**Date of Birth:**

**Name of young person:**

Name:

Relationship to young person:

Email address:

Mobile number:

Do you consent to text messages?

Do you consent to voicemails being left?

Do you consent to email communication?

Preferred method of contact:

**What is the main reason for referral? Please include thoughts feelings and behaviours:**

**Details of person completing referral form:**

**School:**

**Confirmation young person is aware of and consents to referral:**

**referral**

YES/NO

**How long has the problem been going on for?**

**Has the young person ever experienced suicidal thoughts? If so, have they ever made plans of suicide?**

**Are there any other services supporting the young person/family? (e.g. CAMHS, early help)**

**What can make the problem worse? Consider places/people/events.**

**What can make the problem better? Consider places/people/events.**

**What is the problem like in different settings? Consider home/school/socialising with others?**

**Please be aware that Service availability is Wednesday-Friday within the standard working day. We will try our best to offer appointments on days/times that suit you. However, we ask you to be as flexible as possible due to high demand for our service.**

**Is the young person at risk of harm from others? Please detail**

**Have you noticed any changes in the young person’s ability to look after themself?**

**Has the young person ever had thoughts of harming others? Have they ever acted on these thoughts?**

**Has the young person ever had thoughts of harming themself? Have they ever acted on them?**