Children's Health Scotland

Promoting the healthcare rights and needs of children and young people

LOTHIAN SELF-MANAGEMENT REFERRAL FORM

Referral Details:	
Name:	
Name of Parent / Carer:	
Date of Birth:	
Address:	
Telephone:	
Mobile:	
Email:	

Medical Condition *(please tick all applicable)*

☐ Diabetes ☐ Asthma ☐ Arthritis ☐ Cancer/leukaemia ☐ Bowel Disorder

☐ Epilepsy ☐ Chronic Pain ☐ ME/Chronic Fatigue ☐ Cerebral Palsy

☐ Other chronic condition *(specify)* _____

Notes or Additional Information:

Does the young person wish a Parent/Carer to be informed of this referral and to be sent information about the project?

Yes ☐ No ☐ (please tick to indicate)

If yes, please tell us their Name *(and address if not the same as above):*

Referral Method: (please complete **referrer's** details)

☐ Self-Referral ☐ NHS Lothian ☐ Other (please specify)

Name:
Contact Details:
Designation: *(NHS Only)*

I confirm that the young person is aware that a referral has been made to the Lothian Self-Management Programme ☐

Signature: **Date:**

What next:

Completed forms can be posted or emailed using the details below:

Children's Health Scotland
Lothian Self Management Programme
22 Laurie Street, Edinburgh
EH6 7AB
Email: simita.kumar@nhs.net. **Tel**: 07483 973320

The Project Officer will contact you by phone to talk about the workshops and answer any questions you may have. You will also be sent or given information about upcoming workshops and programmes.

Multi-Agency Consent Form

The Project Officer has discussed with me that there may be occasions when certain information about my progress during the project may need to be shared with other professionals involved with me.

I understand that as far as possible, staff will advise or inform me of the specific information which will be shared and with whom. I agree that this information can be shared. I understand that my information will be shared only with professionals in the agencies involved in my care. This may involve Local Authority services, such as education, social work services, healthcare professionals, and voluntary agencies. By signing this form I agree to this information being shared with these agencies.

Name (Print)	
Signature	
Date of Birth (of participant)	
Date of signing	

Please note: Parent/Guardian must co-sign form if participant is under 16.	
Name (Print)	
Signature	
Date of signing	

Equality and Diversity Form

Children's Health Scotland is committed to promoting equality of opportunity, to ensure that everyone has the chance to participate in what we do. You can find out more here: https://www.equalityhumanrights.com/en/equality-act-2010/what-equality-act

Race		
What is your ethnic group? (choose one section from A to F, then put X next to the one that best describes your ethnic group or background)		
A. White	Scottish ☐	Other British ☐
	Irish ☐	Polish ☐
	Gypsy / Travellers ☐	
B. Other white ethnic group	Please write in:	
C. Mixed or multiple ethnic groups	Any mixed or multiple ethnic groups, please write in:	
D. Asian, Asian Scottish or Asian British	Pakistani, Pakistani Scottish or Pakistani British ☐	Indian, Indian Scottish or Indian British ☐
	Bangladeshi, Bangladeshi Scottish or Bangladeshi British ☐	Chinese, Chinese Scottish or Chinese British ☐
Other, please write in:		
E. African	African, African Scottish or African British ☐	Other, please write in:
F. Caribbean or Black	Caribbean, Caribbean Scottish or Caribbean British ☐	Black, Black Scottish or Black British ☐
Other, please write in:		
G. Any other ethnic group	Arab, Arab Scottish or Arab British ☐	Other, please write in:

Refugees and Asylum seekers		
Are you or have you been a refugee or asylum seeker in the UK?	Yes ☐	No ☐
If yes, what is your nationality or country of origin? Please write in:		

Religion or belief : What religion, religious domination/body do you belong to:		
None	Church of Scotland	Roman Catholic
Other Christian	Muslim	Buddhist
Jewish	Hindu	Sikh
Pagan	Other, please write in:	Prefer not to say