Self-Management Service: Professional Referral Form

Referral Details	
Child/Young Person (CYP) Name:	
CYP Date of Birth:	
Parent/Carer Name:	
Address:	
Telephone:	
Mobile:	
Email:	

Condition (please tick all applicable)

ADHD	☐	Chronic Fatigue	☐
Anxiety	☐	Chronic Pain	☐
Arthritis	☐	Diabetes	☐
Asthma	☐	Epilepsy	☐
Autism	☐	Heart Disease	☐
Bowel Disorder	☐	Leukaemia	☐
Cancer	☐	Long Covid	☐
Cerebral Palsy	☐	ME	☐

Other condition (Please specify:)	

Notes or additional information that will help us to process your referral:

Parent / Carer Details		
Does the CYP wish a Parent/Carer to be informed of this referral and for the Parent/ Carer to be contacted about the Service?	YES ☐	NO ☐
If yes, please add contact details if different to above.		

What are you hoping the Self-Management Service can help the CYP with?	
Does the CYP have a preference for the online programme, SMS: CONNECT, or the in-person programme in Edinburgh, SMS: F2F?	SMS: CONNECT ☐ SMS: F2F ☐ Both ☐

Referrer Details	
Name:	
Designation & Organisation:	
Contact details:	
Other Professional Contact (e.g. school professional or medical professional)	
Name:	
Designation & Organisation:	
Contact number:	
Address:	
I confirm that the CYP is aware that a referral has been made to Children's Health Scotland's Self-Management Service:	YES ☐ NO ☐
Signature:	Date:

Please return the completed Referral Form to the Self-Management Service by post or email using the contact details below.

Self-Management Service: Contact Information

Michelle Wilson

Head of Children's Health and Wellbeing Services

Children's Health Scotland

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