Self-Management Service: Self-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:

Programme Details	
What are you hoping the Self- Management Service can help your CYP with?	
How did you hear about the Self-Management Service?	

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 ☐

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. We will let you know that we received it and we will contact you to discuss your referral as soon as we can.

Self-Management Service: Contact Information

Michelle Wilson

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