Mind for better mental health | Mid and North Essex

**Head Office**
The Constantine Centre, 272a Mersea Road,
Colchester, Essex CO2 8QZ
t: 01206 764600
f: 01206 546478
e: enquiries@mnessexmind.org

# Children & Young People Service Referral Form

Thank you for referring to our service. Please ensure the young person being referred is aware of and agrees to referral before completing.

Name of Young Person: Date of Birth:

Home Address: Postcode:

Tel (home) Tel (mobile) Email

Name of school:

Name and address of GP:

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Next of Kin: Relationship to young person

Address: (if different from above)

Postcode: Tel (home) Tel (mobile)

If over 13 years, does the young person wish for their next of kin to be made aware of this referral YES NO

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What does the young person feel they need support with?

Any relevant history (family history/significant events/ loss etc.)

Does the young person agree to the referral? YES NO
Does the young person attend school/college regularly? YES NO
Does the young person have any diagnosed conditions? (inc. Autistic spectrum Disorders) YES NO
Please list any diagnosed conditions or **any** other services (e.g. Social care) involved with the young person here:

Safety of the young person:
Has the young person ever self-harmed YES NO
Has the young person every experienced suicidal thoughts/attempted suicide YES NO
If **YES to either above** please provide details of risk assessment that has taken place:

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Name of Referrer: Relationship to Young Person:

Address:

Postcode: Tel: Email:

How did you hear about our service?

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Signed: *(Referrer)* Signed: *(Young Person, if present)* Date:

**For reasons of confidentiality and data protection, we are unable to accept referrals by email. Please return form by hand, post or fax.**

| For office use only: | |
|---|---|
| File No: | |
| Date Received: | |



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Reg. Office The Constantine Centre, 272a Mersea Rd, Colchester, Essex CO2 8QZ