Children's Health Scotland

Self-Management Service: Professional Referral Form

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

Medical Conditions (please tick all applicable)	
Arthritis	☐
Asthma	☐
Bowel Disorder	☐
Cancer	☐
Cerebal Palsy	☐
Chronic Fatigue	☐
Chronic Pain	☐
Diabetes	☐
Epilepsy	☐
Leukeamia	☐
ME	☐
Other long-term condition (Please specify:)	

Notes or additional information:

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

Referrer Details			
Name:			
Designation & Organisation:			
Contact details:			
I confirm that the CYP is aware that a referral has been made to the 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 overleaf.

Self-Management Service: Contact Information

Laura Smith

Head of Children's Health & Wellbeing Services

Children's Health Scotland

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