**Child Healthy Weight Self Referral Form**



**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of referral: \_\_\_/\_\_\_/\_\_\_**

**Date of birth: \_\_\_/\_\_\_/\_\_\_\_\_\_**

|  |
| --- |
| **Address:**  **Parent/Guardian Telephone:**  **Parent/Guardian Email:** |

|  |  |  |
| --- | --- | --- |
| **Gender - Please tick** | | |
| Male | Female | Do not identify as male or female |

**Please indicate which pronouns the child/young person prefers:**

He/him She/her They/them

**Will you need an Interpreter? Yes No**  **Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Reason for referral –what do you hope to achieve by attending the service?**  **Any physical disabilities or emotional wellbeing concerns that would be helpful to share?**  **Any concerns about potentially attending a group?** |
| **Child/Young person/Parent/Guardian’s signature:** |

**If you would like to discuss the referral with us or need help filling it out, please contact us on 0131 537 9169 or email at:** [**loth.childhealthyweight@nhslothian.scot.nhs.uk**](mailto:loth.childhealthyweight@nhslothian.scot.nhs.uk)

Thank you for completing this form. Please post it to: Lothian Weight Management Service, Woodlands House, Astley Ainslie Hospital, Canaan Lane, Edinburgh, EH9 2TB or email us at: [loth.childhealthyweight@nhslothian.scot.nhs.uk](mailto:loth.childhealthyweight@nhslothian.scot.nhs.uk)