**Child Healthy Weight Self Referral Form**

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

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

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

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **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**

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