Compass Phoenix supports **children and young people aged 9 – 19** (up to 25 for those with special educational needs or disabilities) with **mild to moderate emotional wellbeing and mental health** issues.

Our dedicated team of **Emotional Wellbeing Practitioners** provide time-limited one-to-one or group work sessions (usually around six), these are designed to support children and young people make improvements to their long-term **health, resilience, and emotional wellbeing**.

If you have any difficulty, or need support completing this form, please contact us on **01904 661916** or Freephone 0800 008 7452 and we will be happy to help in any way we can.

So that we can make sure you get the right help we need to know a little bit more about your child.

**Who is making this referral?**

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| I am the parent/carer or significant other of the **child/young person** Yes |
| Does the child/young person agree to this referral?Yes  No |

|  |  |  |
| --- | --- | --- |
| Details of the **child/young person** | | |
| Name |  | |
| Address and postcode |  | |
| Contact phone number |  | |
| E-mail Address |  | |
| Date of Birth |  | Age |
| Gender | male / female / transgender / non-binary/ I describe myself in some other way / I prefer not to say (delete as appropriate) | |

|  |  |
| --- | --- |
| Details of **parent/carer** or significant other | |
| Name |  |
| Address and postcode |  |
| Contact phone number |  |
| E-mail Address |  |

**Please note that all correspondence will be by e-mail unless you state otherwise.**

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| --- | --- |
| Name of G.P surgery |  |
| Name of school/college |  |

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| Please give a brief description about what your child/young person would like support with: | | | | | | | | | | | |
| Please indicate what the main problem seems to be:   |  |  |  |  | | --- | --- | --- | --- | | Stress |  | Conduct difficulties /emotional regulation  e.g. feelings of anger |  | | Bullying |  | Self-harm |  | | Anxiety |  | Body image |  | | Low mood |  | Eating problems |  | | Self-esteem |  | Bereavement/loss |  | | Social Isolation |  | Suicidal thoughts |  | | Other (please give details): | | | | | | | | | | | | | | | |
| On a scale of 1 – 10, please indicate how much this problem impact on the child/young person’s ability to go about their day-to-day life:  1 being not at all, and 10 being very much | | | | | | | | | | | |
|  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Not at all Very much | | | | | | | | | | | |

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| **Consent Statement** |
| By completing and submitting this form you are giving your consent for Compass to store the information held on this form on a secure database. |

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| Please email your completed Request for Support form to: **phoenix@compass-uk.org**  Once in receipt of your email Compass store client information securely however Compass cannot accept responsibility for the security of your details while the email is in transit. |