MHST Self-Referral Form

Name	DOB:
Tutor/Class teacher:	
Other professionals you talk to: (name/role)	Are your parents aware of this? Yes No Are school staff aware of this? Yes No

Reason for referral: How are you feeling?
What impact is this having on your wellbeing?
How long has this been going on?
Have there been any big family events or illnesses?
Additional information:

Signed: **Printed:**

Date

For MHST Use Only	
Start date:	Assigned EMHP/FW:
Review date	
Need for referral to SPA/other services?	