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| **QuitReady Young Persons Referral Form (12-17 years)**  |
| Name:  |
| Date Of Birth |  | Age |  | Year Group |  |
| Home Address:  |
| Telephone/Mobile number: |
| E-mail Address: |
| Name of School Attending: |
| School Year Group |
| Are you self-referring  | Yes: | No: |
| **Referrer’s Details:** |
| Referrers Name: |
| Relationship to Young Person: |
| Telephone/Mobile number: |
| E-mail Address: |
| School/Organisation: |
| Are there any safeguarding Concerns?  |
| Yes: | No: |
| Named Social Worker |
| Has the Young Person given consent for the referral to be sent to the Quit Ready stop smoking service for help and support? |
| Yes: | No: |
| Is the young person a young carer. |
| Yes: | No: |
| **Doctors**  |
| Name of Surgery |
| Address  | Telephone Number |
| **Health Conditions:** |
| Asthma  | ADHD | Autism | Anxiety  |
| Depression | Other Health Conditions |
| **Is the young person on any prescribed medication? please list below** |
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| **Reason for the Referral:** |
| To stop smoking: | To stop vaping: |
| To stop smoking & vaping: | For advice on smoking & vaping: |
| Are the parents/carers of the young person aware of the referral? |
| Yes: | No: |
| **Parent/carer contact information:**  |
| Name:  |
| Relationship to Young Person:Address: |
| Telephone/Mobile number: |
| E-mail Address: |
| **Please email referral form to:** **quitreadyyp@leics.gov.uk** |
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