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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** | | | | | | | | |
|  | | | | | | | | |
| **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**](mailto:quitreadyyp@leics.gov.uk) | | | | | | | | |
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