Disabled Children's Services

Sleep Counselling Referral

This form must be completed by the family requesting support

CHILD DETAILS:		
First Name:	Surname:	
DOB:	Gender:	Ethnic Origin:
Address: Postcode:		

Mother's name, address and contact numbers
Father's name, address and contact numbers
Number of siblings and ages:
Please state if your child has his/her own room: Yes/No
G.P Practice and Address:
Diagnosis or nature of additional needs
Medication (if any)
School or nursery:
Does your child have a key worker: Yes/No Name of key worker and contact number:

SLEEP DIFFICULTIES:

Are your child's sleep problems in relation to:

Settling ☐ Night waking☐ Early morning (before 5 am) waking☐

Please briefly describe the problem and how it affects the family:

Do you see any professional regularly regarding this problem? Yes/No

Name:
Occupation:
Address;
Tel no:

Please note that children and young people currently receiving CAMHS and other highly specialist services may not be suitable for this service Referrers are advised to phone Sleep Counsellors via AccessPoint on 020 8770 4690 to discuss prior to referring.

Are you prepared to put in a new sleep programme for your child based on the recommendation of the sleep counsellors?
Comments:

Data Protection
I understand that my family's information will be stored and used for recording, referral and research purposes

Parents signature:

Date:

Sleep counsellors have received training from Sleep Scotland. More information about Sleep Scotland's programmes can be found on www.sleepscotland.org

Please return this form to;
Sleep Counselling
Disabled Children's Service
Sutton Civic Centre
St Nicholas Way
Sutton, SM1 1EA.