

# Parent Guided Self Help Anxiety Group

Name of Child					
Date of Birth		Year group		Gender	Male
First Language		Ethnicity			Female
Phone Number:		Email Address:			
School:		Home address:			
NHS number (If you can't find this number, please don't let this stop you asking for help.)					
Name of GP					
GP Address:					
Consent to inform GP of referral to our service: Yes      No					

**Tell us a little about your child's worries or fear.**  
 You don't need to provide a lot of detail but please make sure you include the following: What impact is this having on your child's everyday life? At home? At school? In the community?

**What have you already tried to help with these difficulties?**

**Are you involved with any other services on behalf of your child (e.g., Place2Be, Up, CAMHS, social care) to support your child? If yes, please state below:**

**Are there any other things you think it would be helpful for us to know?**  
 (e.g. parental relationship difficulties, additional learning needs, recent bereavements or other changes in circumstances, other services involved)

Completed by (name): ..... Signature: ..... Date: .....

Please return this form to [wandsworthwp@swlstg.nhs.uk](mailto:wandsworthwp@swlstg.nhs.uk)

**If your referral is accepted, yourself and your child's school will be notified.**