S.H.A.P.E

Support, Help and Advice for Problem Eating

y.e.s. supporting young people

Referral Form

Name:	**Date:**
Address:	**School/College/Work:**
Age:	**Date of Birth:**
Contact Number:	**Contact Email:**
Best time to contact:	**Alternative Contact:**
Parent/Carers Mobile:	
Height:	**Weight:**
BMI (if possible):	
Please give details of any other services you have received support from:	
Have you received a service from any EWMHS Team, or are you in the process of being referred to them? Please give details:	
Referred by (e.g. Self/Parent/School/GP or Other):	
GP Details **Name:** **Address:** **Telephone Number:** **(**We may require you to consult with your GP in the following few weeks**)**	
If you are under 16 years of age please complete the details below **Name of Parent(s)/Carer(s):** **PLEASE HIGHLIGHT THIS BOX IF YOUR PARENTS ARE NOT AWARE OF THIS REFERRAL** ☐	
Signed:	
Please return all completed forms to: Lucy Ilsley Colchester and Tendring Youth Enquiry Service 9 Trinity Street, Colchester, Essex, CO1 1JN info@colchesteryes.org.uk	