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| --- | --- | --- |
| A little about you | | |
| First Name |  | |
| Surname |  | |
| *Age* |  | |
| Full Address inc postcode |  | |
| Tel number |  | |
| Email |  | |
| GP Full Name and Address |  | |
| Parent or young person referring? |  | |
| Where did you hear about us |  | |
| Are you happy for us to contact you via | Phone  Email  Post addressed to me | |
| A little about what is challenging you | | |
| What best describes your current difficulties? | Low Mood  Anxieties / worries / fears  Behavioural difficulties in child under 10  Anger  Low mood and anxiety  Difficulties with stress  Difficulties with Sleep  Difficulties following trauma  Difficulties with behaviours you have to complete to feel ok | |
| Over the last two weeks (14 days) how bad have your difficulties been on a scale from 10 to 100, with 100 being the worst experience possible |  | |
| Over these two weeks, how many days have felt as bad as you scored above | 1-4  5-9  0ver 10 days | |
| How many months have you had these difficulties |  | |
| How many other different times in your life have you experienced these same difficulties |  | |
| A little about the impact of your difficulties  Please rate from 100 (100 being the biggest impact imaginable) the impact of your difficulties on each of these areas of your life | | |
| School |  | |
| With friends |  | |
| Home / with family |  | |
| A little about your safety | | |
| Do you purposely hurt yourself when you have difficult feelings |  | |
| How often do you hurt yourself |  | |
| Do you hurt yourself to the point where you need medical treatment e.g stitches, bandages, etc |  | |
| Do your difficult feelings lead you to have thoughts about ending your life on purpose? |  | |
| Do you have plans about how you would purposely end your life? |  | |
| Have you tried to act on these plans within the last three months? |  | |
| Past difficulties (over three months ago) | | |
| In the past, have you purposely hurt yourself when you have difficult feelings? |  | |
| How often did you hurt yourself |  | |
| Did you hurt yourself to the point where you needed medical treatment? E.g stitches, bandages etc |  | |
| Did you difficult feelings lead you to have thoughts about ending your life on purpose? |  | |
| Did you make plans about how you would purposely end your life? |  | |
| Did you try to act on these plans more than three months ago? |  | |
| How many times before have you acted on these plans? |  | |
| Tell us a little more about how you overcame these experiences so they are not still a difficulty for you |  | |
| Sense of safety from, or to, others. | | |
| Feeling as you do, do you think that you could or would harm anyone else? Please reply yes or no and give details | |  |
| Do you have someone in your life who you worry could, or does harm you? Please reply yes or no and give details | |  |
| If you are a young person, is there someone in your life who you feel that you look after, other than yourself? Please reply yes or no and give details | |  |
| A little about what you want to change | | |
| How important is it that you male changes to how your feelings impact your life (0= not important to 100 = the most important thing) | |  |
| How motivated are you to use the tool and support materials to help you make changes? 0=not motivated, 100 = completely motivated | |  |
| How confident to you feel about being able to make these changes? 0= not at all confident to 100 = completely confident | |  |
| Are there any additional challenges in your life that could prevent you from being able to make these changes? Please reply yes or no and give details | |  |
| Imagine, if as you go to sleep tonight, a miracle could happen that took away all the difficulties you have been experiencing. When you wake up tomorrow morning, what would you notice or see and what would you be able to do, for your to know that the miracle had happened. Please provide as much detail as you are able | |  |
| Is there anything else that you would like to tell us about your difficulties? | |  |
| Please confirm that you are aged 13 and over, or a parent of a young person aged 12 and under and that you have read the confidentiality and consent policy <https://www.cypaccept.co.uk/confidentiality-privacy-and-consent> on the website. This explains how we use, store and keep private the information that you tell us | |  |
| Please take the time to **complete all of these questions**. We will not be able to look at your referral without all of this detail.  Please also be aware, that if you tell us that you currently have plans around ending your life, it is our duty of care to pass this information on to your GP, so that they can support your care and safety.  You are welcome to return this form via email to [cyp.accept.clinic@exeter.ac.uk](mailto:cyp.accept.clinic@exeter.ac.uk), but please be aware that this is a university address and therefore is not built for secure transfer of confidential email in the same way as an NHS email address.  If you want to post this, please return your form to  CYP-AccEPT  Henry Wellcome Building for Mood Disorders Research  Exeter University  EX4 4QG  01392 726449 | | |