

SLEEP SCOTLAND

CHILD'S PERSONAL INFORMATION

Please complete, **sign** (page 2) and return form to: **Sleep Scotland**
Freepost SC05340
Edinburgh EH8 0BR

CHILD DETAILS:			
First Name:		Surname:	
Address:			
Postcode:			
DOB:	Age:	Sex:	Ethnic Origin:
GP Practice: Address:			
Postcode:			
Diagnosis (if any):			
Medication (if any):			
School/Nursery:			
Number of Siblings:		Please state if your child has his/her own room: Yes/No	
Does your child have a key worker: Yes/No			
Name:			
Address:			
Tel no:			
Are your child's sleep problems:			
Settling <input type="checkbox"/>		Night waking <input type="checkbox"/>	Early morning waking <input type="checkbox"/>
Please briefly describe the problem. For example: how long it has lasted, what your child does and how it affects the family.			
PARENT/CARERS' DETAILS:			

Mother's Name:	Father's Name:
Home Telephone No and/or Mobile No:	
Occupation Mother:	Occupation Father:
Work Telephone:	Work Telephone:
Do you have any respite care? (please state where and how much)	
Any other information you might think relevant?	
Do you see any professional regularly regarding this problem? Yes/No	
Name: Occupation: Organisation: Address: Tel no:	
Referred by professional	
Name: Occupation: Organisation: Address: Tel no:	
Please note that Sleep Scotland requires signed consent from a parent to hold, record and pass on this form to the appropriate Sleep Counsellors.	
Would you consider receiving Sleep Counselling via Video link? Yes <input type="checkbox"/> No <input type="checkbox"/> Perhaps <input type="checkbox"/>	Would you be willing to talk to the media about your situation? Yes <input type="checkbox"/> No <input type="checkbox"/> Perhaps <input type="checkbox"/>
Do you want to work with Sleep Counsellors on your child's problems? This would involve regular attendance at a convenient location. Yes/No	
Comments:	
Data Protection: I understand that my family's information will be stored and used for recording, referral and research purposes. Parent's Signature: Date:	For office use only: Date received: HG <input type="checkbox"/> EV <input type="checkbox"/> JA <input type="checkbox"/> FILE <input type="checkbox"/>