

Student details

a Customer Reference Number

Title

 Mr Mrs Miss Ms

Forename(s)

Surname

Address

Date of Birth

Day Month Year

 / /

b Does this person in your professional opinion have a mental health difficulty which may well last for a year or more?

 Yes No

c Diagnosis / working diagnosis:
(If it is not possible to give a diagnosis or working diagnosis please explain why)

d Main symptoms of the condition (especially those which may have an impact on study eg concentration, memory or motivational difficulties, anxiety or paranoia)

e Your Job Title:

f The nature of your professional involvement with the student (if this is not apparent from your job title)

g The type of organisation you work for:

GP Practice

Primary Care Mental Health Team (including IAPT services)

Secondary Care Mental Health Team (including EIP, Crisis Teams, Community Mental Health teams etc)

Hospital Based Mental Health Team

Other (please specify)

h The name and contact details of the organisation you work for (where possible please use your agencies' stamp – alternatively please also include a covering note on headed paper)

Your signature

X

Today's date

Day	Month	Year
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Please return your form by post to:
Student Finance Wales
PO Box 211
Llandudno Junction
LL30 9FU
or by email to: SFW_DSA_Team@slc.co.uk