

Mental Health Evidence form

Student details

a	Customer	Reference	Number

Title

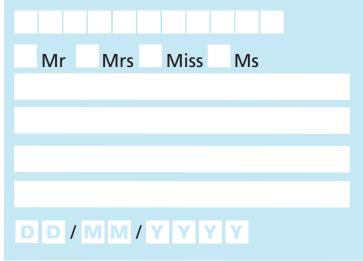
Forename(s)

Surname

Address

Date of Birth

- b Does this person in your professional opinion have a mental health difficulty which may well last for a year or more?
- 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)
- Your Job Title:



Yes No			
	Yes	No	

Γ		
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	Date
X	DD/MM/YYYY

Please return your form by post to: Student Finance England PO Box 210 Darlington DL1 9HJ

Or by email to: dsa_team@slc.co.uk