**Dudley School Nursing Service Referral Form**

**Child or Young Person’s Details**

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| --- | --- | --- | --- |
| **Name:** |  | **Date of Birth:** |  |
| **Address:** |  |
| **Gender:** |  | **Ethnicity:** |  |
| **NHS Number:** |  | **GP:** |  |
| **School:** |  | **CP** [ ]  | **CIN** [ ]  | **CIC** [ ]  | **EH** [ ]  |
| **Allocated Social Worker:** |

|  |
| --- |
| **Please confirm parent / carer consent has been obtained (primary school children only).** **Yes** [ ]  **No** [ ] **If consent has not been gained, please explain why:** |
| **Please confirm young person’s consent has been obtained****Yes** [ ]  **No** [ ]  **If consent has not been gained, please explain why:** |

**Parent / Carer details
Please ensure ALL details are complete.**

|  |  |
| --- | --- |
| **Name:** | **Name:** |
|  |  |
| **Address:** | **Address:** |
|  |  |
| **Contact Tel. No:** | **Contact Tel. No:** |
|  |  |
| **Relationship to child:** | **Relationship to child:** |
|  |  |
| **E-mail address:** | **E-mail address:** |
|  |  |
| **Professional making the referral** |
| **Name/Job Title:** |  | **Contact Tel. No:** |  |
| **School / Agency:** |  | **E-mail address:** |  |

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| **Reason for referral:** |

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| --- | --- |
|  | Continence (**basic advice & sign posting**) |
|  | Dietary advice / Weight Management |
|  | Sleep |
|  | Smoking / Vaping cessation support |
|  | Emotional Health & Wellbeing **(tier 1 low level support)** |
|  | Medical issues / care plan |
|  | Substance Misuse **(signposting to Here 4 YOUth)** |
|  | Sexual Health **(basic advice and signposting)** |

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| **What specific interventions have been implemented for the child by school beyond the universal support that is offered to all children.** **What interventions have been implemented by the parents to address the concerns?****(IF THIS BOX IS LEFT BLANK OR NOT APPROPRIATLY COMPLETED, THE REFERRAL WILL BE RETURNED TO YOU)***(Please refer to Referral Pathways)* |
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| **Other Services / Professionals involved:****PLEASE NOTE: IF THE REASON FOR YOUR REFERRAL IS LINKED TO THE REASON THE CYP IS UNDER ANY OF THE BELOW SERVICES, SCHOOL HEALTH WILL NOT ACCEPT THE REFERRAL. In this instance we advise that direct contact is made with the service the child / young person is under.**  |

|  |  |
| --- | --- |
|  | CAMHS |
|  | Educational Psychologist |
|  | School Counsellor |
|  | Paediatrician |
|  | Hear 4 Youth |
|  | What Centre / any other form of counselling service |
|  | Bereavement Support |
|  | GP |
|  | Young Carers |
|  | \*Other (Please give details below) |

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| Other details: |
|  |
| **Please confirm the child/young person’s attendance:PLEASE NOTE: THE YOUNG PERSON MUST BE REGULARLY ATTENDING SCHOOL FOR SCHOOL NURSING TO ACCEPT THE REFERRAL** |
|  |
| **Please detail what support you require School Health to provide to this young person** |
|  |
| **PLEASE NOTE: IF THERE ARE 3 UNSUCCESSFUL ATTEMPTS TO CONTACT CHILD/PARENT, CHILD WILL BE DISCHARGED FROM SCHOOL NURSING SERVICE.**  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |

 **For School Nursing Service only**

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| **Date referral received:** |  |
| **Allocated to:** |  |
| **Action taken:** |  |

**Please choose appropriate School Nurse Team to send your referral to:**

