

**NHS SCHOOL NURSING SERVICE REFERRAL FORM**

**Please refer to the Guidance: Referral Pathway for School Nursing Assessment**

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| **Child’s Name:****Known as (if different to their registered name):** | **D.O.B:** | **Child’s Next of Kin:** |
| **Child’s School:** | **Year Group:** |
| **Child’s Address:****Postcode:** | **Phone number(s):*****Please include the young person (if aged above 13y)*** |
| **NHS number** (if known)**:** **GP** (if known)**:** | **Ethnicity:** **Is an interpreter required? Yes / No****If yes which language?** |
| Please ensure ALL Secondary School referrals have the Young Person ’s consent – it is not necessary to gain parental consent for Secondary School pupil referrals but is strongly advised where possible. Referrals will only be accepted with consent.**Please confirm that you have discussed this referral with a parent/guardian with parental responsibility Yes / No****Have you obtained parental consent to share information with School Nursing services Yes / No****Is the child / young person aware of the referral and given consent? Yes / No** |
| **Reason for referral** **What are the main issues? How long has this been an issue and how is it impacting on the young person?****What does the child or young person report (if appropriate?)****What is working well?****What is your desired outcome from School Nurse Team intervention?****Please tick when the Safety Plan** (on Page 3) **has been discussed with the young person, parent/carer □** |
| **Outside agencies involved with student/family and contact details of relevant parties:****CAMHS □ Social Services □ Youth Justice Services □ Early Help □****Counselling □ BDCFT Mental Health Support Team (MHST) □****Educational Based Emotional Wellbeing Practitioners (EEWP) Team □****Other** (Please specify)**Name and contact details of allocated worker** (if appropriate):\*\* Please note that we cannot accept duplicate requests for support and if a referral has also been requested to another appropriate service, we cannot accept your referral. We also cannot provide support if a referral has been accepted by another service which have long waiting lists. Please liaise with this service directly. |
| **Current parent and/ or school action** (what has already put in place to support the child?)  |
| **Name of referrer:****Email:****Contact Number:** | **Date of referral:** |
| **Please confirm that you have provided supporting information if required:** |

**Please email a copy of all necessary forms (plus any additional templates) to secure email address** **admin.services@bdct.nhs.uk** **ensuring subject field on e/mail says School Nursing referral.**

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**Please read and discuss with the young person and parent/carer**

**Safety Plan:**

* **Concerns have been discussed with urgent services (if appropriate) who have recommended a non-urgent School Nurse Service referral**
* **Parent/ carer and young person have been given the contact details for First Response, should they be required.**
* **The parent/ carer and young person are aware that they can also access their GP during working hours for support. In a medical emergency they should call 999. In a mental health or emotional crisis, they should call First Response (0800 952 1181). They can also contact NHS 111 or visit their local A+E Department.**

**The Young Person can access the following online support services which offer a confidential advice and support service.**

[**https://www.kooth.com/**](https://www.kooth.com/)

[**https://www.youngminds.org.uk/young-person/**](https://www.youngminds.org.uk/young-person/)

[**https://www.childline.org.uk/get-support/**](https://www.childline.org.uk/get-support/)