

**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**](mailto: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/)