

**NHS SCHOOL NURSING SERVICE REFERRAL FORM**

**Guidance Information for Referral to BDCFT Family Health Services**

BDCFT Family Health Services which include School Nursing, can offer limited interventions to children, young people and/or families please see below the criteria for those interventions.

* Primary Nocturnal Enuresis – Bedwetting (never been dry)
* Child Emotional Health Concerns including low mood, abnormal levels of anxiety/ panic attacks, bereavement, self-harming.
* Support or signposting for children with unmet physical health issues, who are not yet under the care of specialised services.
* Children who require assessment and onward referral for suspected Autism/ADHD type behaviours (see Essential Referral Criteria below)

This list is not exhaustive and if you are unsure please contact a member of the Family Health Services team to discuss the referral further contact **01274 221203** and ask for School Nursing.

**Please email a copy of all necessary forms (including 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.**

**Please ensure all concerns are documented within the referral form and not in the body of the e/mail**

**Essential Referral Criteria**

For cases of suspected Autistic Spectrum Condition (ASC) there are different referral pathways depending on age:

**Under 7 year – ASC referral process**

Referrals to either Bradford or Airedale CDS (child development service) can be completed and sent directly from school SENCO or specialist teacher, please see table below for details of referral process and forms.

Refer to ANHSFT or BTHFT as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| Under 7 year autism referral | Referrals pathway | Referrals accepted from | Referral form |
| Airedale (ANHSFT) CDS | * Send to [cdc.referrals@nhs.net](mailto:cdc.referrals@nhs.net) marked ‘Autism assessment referral’. * Send by post to Autism Assessment, Child Development Centre, Airedale General Hospital Steeton, Keighley BD20 6TD | Consultant Paediatrician, Health Visitor, School Nurse, GP, Allied Health Professional, Educational Psychologist, SENCO, Specialist Teacher. |  |
| Bradford (BTHFT) CDS | Via SystmOne  If the referrer does not have SystmOne access a paper referral can be sent to Paige Hayes, CDS Secretary, Third Floor, Extension Bloc SLH, Little Horton Lane BD5 ONA | Consultant Paediatrician, Health Visitor, School Nurse, GP, Allied Health Professional, Educational Psychologist, SENCO, Specialist Teacher. |  |

**7 to 18 years – ASC and /or ADHD referral process**

All cases of suspected Autistic Spectrum Condition (ASC) for 7 to 18 year olds and cases of suspected ADHD any age, will need onward referral to CAMHS.

In order for the School Nurse to send a referral to CAMHS you will need to complete the following in addition to the school nurse referral form:

* Teacher and parent SNAP-IV template (one from teacher one from parent)
* ASC and ADHD Observation template



Any concerns with parenting or behaviour that that is displayed in only one setting i.e. home or school but not both, should be directed to **Early Help 01274-435600** for further support.

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s Name:** | | **D.O.B.:** | | **NHS Number:** | |
| **Child’s School:** | | | | | **Class:** |
| **Child’s Address:**  **Postcode:** | | | | **Phone number:** | |
| **GP:** | **Ethnicity:**  **Is an interpreter required? Yes / No**  **If yes which language?** | | | | |
| **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** | | | | | |
| **Reason for referral**  (Please see overleaf for essential referral criteria). Referrals without necessary supporting information will be returned to referrer. | | | | | |
| **Outside agencies involved with student/family and contact details of relevant parties:**  **CAMHS □ Social Services □ YOT □ Police □ Early Help □**  **CP □ Counselling □ Other** (Please specify) | | | | | |
| **Current school action** (what have you 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:**  **(See guidance information for referral provided)** | | |

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