**Special Needs School Nursing Team Referral Form**

**Please send completed form to:** **CCS-TR.SNSN@nhs.net** **Tel: 01223 218061**

|  |  |
| --- | --- |
| Child/Young Person’s Name: (please print) | School: |
| DOB: | Class: |
| Address: | GP: |
| NHS Number: | Next of Kin:  |
| Parental consent for referral and permission to contact: Yes / NoConsent for SMS: Yes/No Mobile Number……………………………………………………………Consent for Email: Yes/No Email address………………………………………………………………Consent for Video Calling: Yes/No Preferred method of contact: ………………………………………………………………………………………………………… |
| **Please select area of current concern:** |
| Bereavement |  | Continence |  | Diet/Eating Issues |  |
| Emotional/Mental Health |  | Medical Issue |  | Motor Skills |  |
| Sexual Health |  | Sleep |  | Substance Misuse |  |
| Other - please specify: |
| **Reason for Referral:** |
|  |
| **What do you hope to achieve through making this referral to the School Nursing Service?** |
|  |
| **Other agencies involved:**  |
|  |
| **PROFESSIONAL USE ONLY - Known to Social Care/Safeguarding concern:** |
|  |
| Referrer Name: | Signature: |
| Role of referrer: | Date of referral: |
| Contact details: Telephone Number:Email: |
| **For School Nursing Service Only:** |
| Date referral received: | Allocated to: |
| Referral accepted: Yes / No |
| Feedback to referrer:Date:Method: Phone / Email / Face to Face / Letter |
| Acknowledgement to parent / carer:Date:Method: Phone / Email / Face to Face / Letter |
| Action taken: |
| Date Intervention commenced: |