**Special Needs School Nursing Team Referral Form**

**Please send completed form to:** [**CCS-TR.SNSN@nhs.net**](mailto: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 / No  Consent 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:** | | | | | | |
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| **What do you hope to achieve through making this referral to the School Nursing Service?** | | | | | | |
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| **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: | | | | | | |