We CARE through:

Compassion Accountability Respect Excellence

NHS
Hampshire and Isle of Wight Healthcare
NHS Foundation Trust

School Nursing Service Referral Form

Please complete all areas. Forms that are not complete <u>will not be accepted.</u>

Please discuss this referral with Parent/Carers and child/young person

Childs/Young Person Details:	
Forename:	**Surname:**
Also known as:	**Date of Birth:**
Preferred Pronoun:	**Ethnicity:**
Religion:	**School:** **Year group:** **School attendance figure:**
Is an interpreter required? ☐ **Y** ☐ **N** **If Yes what language:**	
Address at which the child/young person is living:	
Child/Young Person contact Number:	**Young Persons Email:**
Permission from Young Person to be contact directly on their mobile number: ☐ Y ☐ N	

Is the child/Young Person (tick all that apply):		
☐ **A Looked After Child**	**Subject to a Child Protection Plan/ CIN plan** **Please give details:**	☐ **A Young Carer**

Parent/ Carers Details:	
Name:	
Relationship to the child:	
Address:	
Parent's/Carer's contact number:	**Parent / Carer Email:**

Is an interpreter required? ☐ Y ☐ N **If Yes what language:**			
CONSENT: Referral must be discussed with the parent/young person and consent gained **Consent and Confidentiality Agreement** **The School Nursing Service provides a confidential service to all our clients including children and young people under 16 years of age. This means that nothing will be said to anyone outside the health team including parents, care workers or teachers without the young person's knowledge, except for safeguarding purposes.** **If you or the young person referred to our service have any worries about confidentiality, please ask the nurse or contact the School Nursing office.**			
CONSENT (This section must be completed, and consent gained):			**If no please give details:**
Does the Parent/Carer know about this referral?	☐ Y	☐ N	
Does the Parent/Carer consent to the referral?	☐ Y	☐ N	
Does the Child/Young Person know about the referral?	☐ Y	☐ N	
Does the Child/Young Person consent to the referral?	☐ Y	☐ N	
Do we have permission to send text/ email messages (your email address may not be secure)	☐ Y	☐ N	
FORWARDING CONSENT: We work closely with other services within the NHS and locally in Southampton:			**Please give details:**
Does the Parent/Carer/ young person give consent to share health information with appropriate services	☐ Y	☐ N	

e.g. GP, other health services, Childrens resource Service, Education?			
Professionals Currently Involved: Please tick all that apply:			**Please give details:**
ELSA	☐ Y		
SENCO	☐ Y		
EWO	☐ Y		
CAMHs	☐ Y		
Children's Resource Service	☐ Y		Name of social worker/family engagement worker:
Therapies Services: Speech and Language/ Occupational Therapy/ Physiotherapy:	☐ Y		Please give details:
Other Health Specialist:	☐ Y		Please give details:
Reason for the Referral/ Why School Nursing Support is Required: Please Tick all that apply: (Please see the attached school nursing guidance for what we can support with)			
Physical Health concerns related to school absences: not chronic or persistent absenteeism:	☐ Y		
Support for healthy lifestyles- diet and exercise:	☐ Y		
Growth concerns:	☐ Y		
Support around Sleep:	☐ Y		
Continence i.e. night/day time wetting, soiling, constipation:	☐ Y		
Support for stopping smoking/vaping:	☐ Y		
Sexual health support:	☐ Y		

Supporting self- care and health literacy.	☐ Y

Please give details of the health need (impact upon the child/young person and family, any relevant medical history, what services have been accessed already and what has already been tried?)

What changes would the child/young person like to see? What does the child/young person understand about this referral?

Parent/Carer: what changes would you like to see?

Referrer: What would you like to happen and the expected outcome?

REFERRER DETAILS:

Name:		**Designation:**
Contact Email:		
Contact telephone:		
Date of the referral:		

We aim to triage and acknowledge referrals within 10 working days.
If you require urgent support, please contact NHS 111 or your nearest emergency department*
If you are concerned for the welfare of a child / young person please contact Social Care or the police

Completed referral forms can be sent to the following generic email address **hiowh.southamptonhvandphnteam@nhs.net** please make sure any referrals or message are sent via your secure email route.
If using SystmOne: Please send task to 'Duty PHN' task group to notify of this completed referral.
School Nursing Service Contact Details: **Telephone: 0300 123 6661** Email: **hiowh.southamptonhvandphnteam@nhs.net**

WE ARE NO LONGER ACCEPTING REFERRALS FOR MENTAL HEALTH or EMOTIONAL WELLBEING, PLEASE SEE THE FOLLOWING SERVICES AND LINKS THAT CAN PROVIDE EMOTIONAL SUPPORT:

- CAMHS: Child and Adolescent Mental Health Service (CAMHS) Southampton :: Hampshire and Isle of Wight NHS Foundation Trust
- Southampton Mental Health in Schools Team (MHST): Mental Health In Schools Team - Southampton :: Hampshire and Isle of Wight NHS Foundation Trust
- School ELSA
- The NHS Website: https://www.nhs.uk/
- Kooth: https://www.kooth.com/
- No Limits: https://nolimitshelp.org.uk/
- Young minds: https://www.youngminds.org.uk/
- Hampshire Youth Access: https://hampshireyouthaccess.org.uk/
- Yellow Door: https://yellowdoor.org.uk/
- Charlie Waller Trust: https://www.charliewaller.org/
- Anna Freud Trust: https://www.annafreud.org/
- Healthier Together: https://www.healthiertogether.nhs.uk/
- Southampton Family hubs: https://www.southampton.gov.uk/children-families/activities-and-support-for-families/family-hubs/
- Family assist: https://solent-family-assist.custhelp.com/app/home