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0-19 **Health and Wellbeing Service Referral Form**

Referral Criteria for Children and Young Peoples 0-19 Health and Wellbeing Service

Any young person, parent/carer can contact a School Nurse directly

Primary School Age	**Secondary School Age**
• Continence issues e.g. soiling, enuresis • Growth, over & underweight concerns • Developmental concerns • Supporting pupils & their families/carers with any newly diagnosed medical conditions • Supporting School staff when they need to produce individual health care plans for pupils • Information, advice and signposting regarding health (physical, behavioural, emotional concerns) • Parental advice regarding identified health needs	• Tier 1 emotional concerns • Advice, information and signposting regarding sexual health issues – *be aware the service does not provide Emergency Contraception)* • Growth over & underweight concerns • Advice and information and signposting regarding lifestyle concerns including smoking, drugs or alcohol • Supporting pupils & their families/carers with any newly diagnosed medical conditions • Supporting School staff when they need to produce individual health care plans for pupils

Please complete and return this form to the 0-19 district HUB via email to FHWS.west@nhs.net

Name of Child	**Date of Birth**
Name & relationship of person with parental responsibility	**NHS Number** **(if known)**
Address	**Contact Telephone Numbers; including any mobile numbers**
School	**Class/Form/Tutor**

Reason For Referral ***(provide as much detail as possible)***
Subject to Safeguarding Plan Yes No **Looked After Child** Yes No **CAF** Yes No **Child in Need Plan** Yes No
Please list any other Agencies involved e.g. Speech & language, Parent Support Worker. Social worker etc.

Please Turn Over

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PARENT/GUARDIAN /YOUNG PERSON (delete as appropriate) CONSENT TO REFERRAL

***** ***REFERRAL WILL NOT BE ACCEPTED UNLESS IT HAS BEEN DISCUSSED WITH & SIGNED BY PARENT/CARER FOR PRIMARY SCHOOL OR PARENT/CARER/YOUNG PERSON IF AT SECONDARY SCHOOL***

PLEASE OBTAIN

Signature of parent/guardian …….. Date ……
(primary/middle school)
OR
Young person ……..Date ……..
(high school)

I DO/DO NOT WISH FOR THE PERSON WHO HAS REFERRED MY CHILD/ME TO BE GIVEN FEEDBACK FOLLOWING ANY INTERVENTION *(Please delete as appropriate)*

Name of Referrer	**Designation**
Address for correspondence:	**Email address**
Phone number (including extension number)	**Please specify the best time to contact you.**
Signature	**Date of Referral**

For Office use only

Source of the referral	**Age of Child:**	**Date referral received and logged**
Was the referral appropriate Yes No		**Level of priority** High Medium Routine
Acknowledgement of referral within timescale Yes No		
Action taken Telephone advice ☐ Seen in School ☐ Home Visit ☐ Written advice ☐ Referral to strengthening families ☐ Other please state.....		
Intervention commenced within : 3 days 5 days 10 days		
Outcome letter sent to referrer Yes No		
Child/Young Persons Health Record completed YES NO		
Comments		

Name of School Nurse (print) ……..

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Signature …… Date……..