**School Health Referral form- Professionals**

For referrals to be accepted, they must have been discussed with the parent/carer/young person (as appropriate) prior to submitting the referral.

**Please ensure the form is completed fully. Failure to do so may result in a delay or automatic rejection.**

|  |  |
| --- | --- |
| **Question** | **Options** |
| Are the parent/carers in agreement with this referral?  | Yes/No |
| Is the young person (if aged 13yrs +) in agreement with this referral? | Yes/No/NA |
| If the referral is for a young person who is deemed Gillick competent, are parents aware? | Yes/No/NA |
| Reason for Referral | * Distressed behaviour
* Emotional Health & Wellbeing
* Health Need eg emergency medication awareness/care plan support
* Healthy Eating & Lifestyle
* Puberty/Growing Up/Sexual Health/Healthy Relationships
* Sleep
* Smoking/Drug/Alcohol use
* Toileting/Continence
 |

**Child/Young Person details**

|  |  |
| --- | --- |
| First name |  |
| Surname |  |
| DOB |  |
| Address |  |
| School |  |
| Year Group |  |
| GP’s name |  |
| GPs address |  |
| NHS number if known |  |

**Parent/Carer details**

|  |  |
| --- | --- |
| Name of person with parental responsibility |  |
| Relationship to child/young person |  |
| Address, if different from child |  |
| Telephone number |  |
| Email Address |  |
| Do they consent to us contacting them by | PhoneTextEmail |
| Additional Information – parental separation, court orders |  |

**Referrer Details**

|  |  |
| --- | --- |
| Name of referrer |  |
| Role/Agency |  |
| Telephone Number |  |
| Email address |  |

**Social History**

|  |  |
| --- | --- |
| Is the child open to children’s social care? | Yes/No |
| If yes, please provide further details and include a copy of the child’s plan |  |
| Social workers name and contact details |  |
| Has Early Help been initiated? | Yes/No/NA |
| If yes, please provide further details |  |

**Reason for Referral**

|  |
| --- |
| Why have you referred today? |
|  |
| What is the child like at home? Please provide examples |
|  |
| What is the child like in school? Please provide examples |
|  |
| How long have the concerns been present? |
|  |
| What are the child’s strengths? |
|  |
| What strategies have been implemented to support the child at a) home and b) in school?  |
|  |
| What does the child/young person feel they need? (Voice of the Child) |
|  |
| What would the parent/s like support with? |
|  |
| Are there any known risk factors for professionals eg violence/aggression to professionals/mental health/drug/alcohol misuse. If yes, please provide further details or put **none** if no known risk factors. |
|  |

**Screening Questions**

|  |  |
| --- | --- |
| Have parent/s accessed any parenting intervention previously? | Yes/No |
| Please explain answer |  |
| Has the child received any emotional wellbeing support eg play therapy, counselling etc? | Yes/No |
| Please explain answer |  |
| Are there any known ACES (Adverse Childhood Experiences) | Yes/No |
| Please explain answer |  |
| Have school implemented core standards? | Yes/No/Don’t know/NA |
| Are there any other services supporting the child and family? Please provide details or type ‘None’ |  |

* I have agreement of the parent/s and/or the child/young person. They agree to information being shared and discussed between professionals and other agencies to help them/their child/young person and family. They understand they can withdraw consent at any time.
* I have considered and managed any identified risks prior to submitting this referral eg safeguarding/self harm

|  |  |
| --- | --- |
| Do you agree with the above statements? | YesNo |
| Date of form completion |  |

**Once the form is completed, please email to medch.childrenscommunity@nhs.net**