**THE INTEGRATED PUBLIC HEALTH NURSING TEAM**

**Referral Form for Active 0-19 Service Intervention**

**To be used in all instances when seeking advice and/or support from the Public Health Service.**

Please read carefully before completing:-

* If the referral is with regard to a child under twelve years of age it can only be processed with signed parental consent. It is the referrer’s responsibility to discuss the concern and the referral with parent/carer before this form is submitted.
* Children/young people twelve years and over may give consent or self-refer via SPoC.
* All sections must be completed and supporting evidence must be provided wherever possible.
* Please return the completed form to Single Point of Contact (SPoC) at address below.

**Single Point of Contact**

**Highlands Health Centre**

**Lothian Way**

**Hull HU7 5DD**

**Tel 01482 336634 / 344301**

**Email:** **Hull.cypcommunityservices@nhs.net**

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| **DETAILS OF CHILD** |
| First Name |  | Date of Birth |  |
| Surname |  | Gender  |  |
| Address | Ethnicity |  |
| Religion |  |
| Main Spoken Language |  |
| Interpreter Required |  |
| Parent/Carer Name & Telephone number | School/Nursery Attending: |
| GP Name & Practice:Address:Telephone: | Name of referrerDate of referralReferrer’s contact details |

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| **PARENTAL CONSENT****A young person aged twelve years or more may give consent themselves if judged to be competent** |
| The information included on this form will be used to assess your child’s need for the Public Health Service. By giving your consent you have agreed that relevant information may be shared with, or obtained from, other professionals and that referrals may also be made to other services if deemed appropriate.Name: ………………………………………………………….Signature……………………………………………………………Relationship to Child: …………………………………….…..Date…………………………………………………………………. |

**Please tick the appropriate box for the service you are referring to:**

**Health Visiting intervention child is: Under 5yrs 5yrs – 11yrs**

**School Nursing intervention**

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| **REFERRAL CATEGORY - please select ONE**  |  |  |
| Behaviour  |  |  |
| Development  |  |  |
| Emotional Health  |  |  |
| Enuresis |  |  |
| Physical Health including growth assessment |  |  |
| PSHE |  |  |

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| **ADDITIONAL INFORMATION TO SUPPORT REFERRAL – do not leave blank****Please describe the nature of the concern including frequency, time scales, environment, who is involved and any interventions delivered to manage concern. Include details of educational issues and measures put in place to support concerns.** **State if the child has any health problems that you are aware of. Do not refer to the Public Health Service if the same concern has been referred to another service.** |
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| **Please indicate if any of the following apply to this child/young person, if relevant to referral.****Please discuss with parent/carer/young person prior to referral and ensure consent is obtained to share information.** |
| **SERVICE** | **YES/NO** | **DATE** | **DETAILS** |
| Community Team for Learning Difficulties (CTLD) |  |  |  |
| Education & Health Care Plan (EHCP) |  |  |  |
| Educational Psychology |  |  |  |
| Health Care Plan |  |  |  |
| Looked After Child |  |  |  |
| SEN/School Action/School Action Plus |  |  |  |
| Social Care Involvement, including name of Social Worker |  |  |  |
| Special Educational Needs |  |  |  |

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| **Is the referrer aware of any reason why a health professional should not visit alone? YES/NO****(If yes please provide details)** |
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