**Public Health Nursing Service Referral**

**Please complete all areas. Forms that are not completed will not be accepted**

**Please discuss this referral with Parent/Carers if appropriate**

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| **Name of Child / Young Person:** | | | | | |  | | | | | **D.O.B.:** | |  | |
| **Gender Identity:** | | |  | | | | | **Interpreter Needed:** | | | | |  | |
| **Religion:** |  | | | | | | | | | | | | | |
| **School:** |  | | | | | | | | **Year / Class:** | | |  | | |
| **Home Address:** | |  | | | | | | | | | | | | |
| **Parent / Carers Name:** | | | | |  | | | | | | | | | |
| **Parent / Carer contact Number:** | | | |  | | | **Parent / Carer Email:** | | |  | | | | |
| **Young Person Contact Number:** | | | |  | | | **Young Person Email:** | | |  | | | | |
| **Permission from Young Person to be contact directly on their mobile number:** | | | | | | | | | | | | | | Yes / No |

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| **Consent and Confidentiality Agreement**  **The Public Health Nursing Service provides a confidential service to all our clients including children and young people under 16. 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 Public Health Nursing office.  I consent to my / my child’s records being shared with other members of the health services and other early years services eg; Children Centres, to provide additional services as required.  If you have provided a mobile number and/or email address above, do you consent to us sending you text messages and emails (your email may not be secure)?** | | | | | | | | | | | | | | | |
|  | | | **Text** | | (Yes / No) | |  | | **Email** | | (Yes / No) | |  | | |
| **We work closely with other services within the NHS and locally in Southampton and can share / obtain your personal details with / from them to provide care to you / your child. If you agree with us sharing / obtaining your details with the following services please indicate below:** | | | | | | | | | | | | | | | |
| **GP:** | Yes / No | | | **Other Local NHS Services:** | | | | Yes / No | | | | **Southampton Early Help Service:** | | | Yes / No |
| **Parent / Carers Consent** | | | | | | **Aware of Referral** | | | | Yes / No | | | | | |
| **Name:** | |  | | | | | | | | **Consent** | | | | Yes / No | |
| **Young Persons Consent** | | | | | | **Aware of Referral** | | | | Yes / No | | | | | |
| **Name:** | |  | | | | | | | | **Consent:** | | | | Yes / No | |

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| **Reasons for Referral / Why support is needed:** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **General Category (Please delete)** | | | | | | | | | | | | | | | | | | | | |
| Physical Health | Emotional Health | | | Healthy Weight | | | | Vision | | Hearing | | | Growth | | | | Long Term Condition | Sleep | | Toileting |
| **Parental Concerns** | | | Yes / No | | | | **Professional Concerns** | | | | | Yes / No | | | | **Young Persons Concerns** | | | | Yes / No |
| **Actions Already Taken / What has been tried to help:** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Expected Outcomes / What will the support change:** | | | | | | | | | | | | | | | | | | | | |
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| **Any other school staff or professionals involved:** | | | | | | | | | | | | | | | | | | | | |
| **ELSA** | **SENCO** | | | **EWO** | | | | **CAMHS** | | **Social Care** | | | | | | | **Social Workers Name** | | | |
|  |  | | |  | | | |  | |  | | | | | | |  | | | |
| **Families Matter / Early Help** | | | | | Yes / No | | | | **Workers Name:** | | | | | |  | | | | | |
| **Speech and Language** | | Yes / No | | | | **Physiotherapy** | | | | | Yes / No | | | **Occupational Therapy** | | | | | Yes / No | |
| **Hospital Dr / Specialist** | | Yes / No | | | | **Other:** | | | | |  | | | | | | | | | |

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| --- | --- | --- | --- |
| **Name of Referrer:** |  | **Designation:** |  |
| **Contact Email:** |  | **Contact Telephone:** |  |
| **Date of Referral** |  |  | |
| \*We aim to respond to 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\* | | | |

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| **Please send this referral via Secure electronic method (Anycomms / NHS.net email)** |
| **Contact Details** |  |
| **Telephone**: 0300 123 6661 |
| **Email:** [snhs.publichealthnursingsouthampton@nhs.net](mailto:snhs.publichealthnursingsouthampton@nhs.net) |
|  |
| **Also Find us on Social Media** |
| **Facebook**: [www.facebook.com/SotonPHNS](http://www.facebook.com/SotonPHNS)  **Twitter:** @SotonPHNS |