SCHOOL NURSING SERVICE REFERRAL FORM

REFERRAL GUIDANCE

How to refer to the Suffolk School Nursing Service

Please complete all sections fully with the involvement of the child / young person and their parents / carers (where appropriate for their age and understanding). Once complete, please submit your referral to: Childrenshealth@suffolk.gov.uk

Please confirm that you have gained parental consent and / or the consent of the young person to make this referral ☐

The School Nursing Service can provide advice and support regarding*:*

Emotional Wellbeing *– e.g. self-harm, low mood, stress, anxiety, self-esteem, bereavement, emotional wellbeing / regulation*
Sexual Health *– e.g. healthy relationships, contraception, sexually transmitted infections, sexual identity, signposting to available services*
Physical Health / Healthy Lifestyles *– e.g. smoking cessation, drug and alcohol use, healthy eating, growth, development, sleep, continence*
Transition stages *– e.g.* transition support for school entry, transition to middle / high school, and school leavers.

Before you complete a referral please be aware:

- **If you are concerned that a child or young person has been, or is at risk of being significantly harmed or abused**, please refer your concerns via our portal: https://earlyhelpportal.suffolk.gov.uk/web/portal/pages/home (or phone 0808 800 4005). If you would like to discuss a welfare concern, please contact the MASH Consultation Line on **0345 606 1499**.
- **For mental / emotional health needs support is also available through the Emotional Wellbeing Hub (except for Lowestoft and Waveney)** via https://www.suffolk.gov.uk/children-families-and-learning/suffolk-children-and-young-peoples-emotional-wellbeing-hub/ or 0345 600 2090 **(**Monday-Friday 08.00 - 19.30).
- **If your concern requires an urgent response,** please contact your doctor or call NHS 111. If it is an emergency dial 999 or visit your local Emergency Department.
- **If a CAF (Common Assessment Framework) is needed,** as the concern is complex or requires multi-agency working, a CAF should be completed via: https://earlyhelpportal.suffolk.gov.uk/web/portal/pages/home

REFERRAL TO SUFFOLK SCHOOL NURSING SERVICE

Please confirm that you have read the attached referral guidance. ☐

Child / Young Person's Details (one referral per child / YP)

Surname:		First Name:				Known as:	
Date of birth:		Address:					
Gender:		Ethnicity:		Language:		Contact Nos:	
School:				School attendance (%):			
GP surgery:				GP Name:			

Do any of the following circumstances apply to the child or young person?

They have disability, condition or support need:	Yes ☐ No ☐ Unsure ☐	If yes, please detail:	
They are a registered or unregistered young carer:	Yes ☐ No ☐ Unsure ☐	If yes, please detail:	
They are receiving support from another professional/s:	Yes ☐ No ☐ Unsure ☐	If yes, please detail:	
One of the following support plans are in place:	Education and Health Care Plan (EHCP) ☐ Family Network Plan ☐ Child in Need Plan (CIN) ☐ Child in Care Plan (CIC) ☐ Child Protection Plan (CP) ☐		

Family (and support network) details

Full name	Date of birth	Their address (if different from the child or young persons)	Ethnicity	Spoken language	Relationship to the child / young people	Do they have parental responsibility?	Phone number	Email address
						Yes ☐ No ☐		
						Yes ☐ No ☐		
						Yes ☐ No ☐		
						Yes ☐ No ☐		
						Yes ☐ No ☐		
						Yes ☐ No ☐		
						Yes ☐ No ☐		
						Yes ☐ No ☐		
						Yes ☐ No ☐		

Reason for referral

What are you worried or concerned about? *What has happened / is happening that concerns you, and what is the impact on you, the family and the child or young person?*	**What is working well?** *What is the child, family, support network or services doing that helps? What is supporting the child / young person regarding your concerns / worries? Who is already helping?*

What do you think needs to happen to help reduce your concerns? *What help, support or advice is needed?*	

Details of all current or previous referrals or requests for help from any services, if known and where relevant

Dates (if known)	**Current or historical referrals or requests**	**Referral / assessment type** *Please include any relevant referrals, requests or assessments that you or others have made, or are aware about for this child / young person or their family*

Referrers' details

Surname:		First Name:		Organisation / Agency / NA:	
Address:					
Role / relationship:				Contact Number:	
Email address:				Relationship to child / YP:	

Please send all completed referrals to: Childrenshealth@suffolk.gov.uk