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| **Health Visitor and School Nurse Referral Form – Devon Integrated Children’s Services** | |
| The following information is required to ensure consistent and equitable access to Public Health Nursing, so that decisions around accepting requests can be made quickly, and in the presence of all the necessary information to complete clinical screening. If Early Help intervention has taken place please provide the Early Help Assessment (previously DAF1) and Request for Additional Services (previously DAF2a – My Plan) in place of sections 1 and 2 of this form. Please ensure that these evidence work that has already been undertaken to support the Child (note that this is a requirement for referral to other ICS specialist Services which we can redirect where appropriate)  **Other ICS Services accesses via SPA include:**  CAMHS, Autistic Spectrum Assessment, Speech and language therapy, Occupational Therapy, physiotherapy, Learning disability Nursing and psychology, Community Children’s Nursing, Palliative care, Rehabilitation Officers for Visually Impaired Children, and the Children with Disability Social Work Team.  [www.integratedchildrensservices.co.uk](http://www.integratedchildrensservices.co.uk)  Tel: **0330 024 5321**  Email: [vcl.devonspa@nhs.net](mailto:vcl.devonspa@nhs.net)  **PHN support includes:**   * + - * Feeding advice * Sleep and routines advice * Difficulties adjusting to parenthood in 1st year * Toileting (including children and young people in school) * Routine parenting * Young people’s mental health and wellbeing advice * Conversations with young people re lifestyle choices and risky behaviours   **See area specific contact details below**  Requests for support that do not include the required supporting information/attached evidence will be returned to the Requestor for completion.  Items highlighted **bold** are required fields. Additional space for answering questions can be found on the last page.  Once completed please send this form and accompanying documentation to one of our PHN Hubs, preferably by email. If you do not have a secure email route or you are unsure if your email route is secure please call or email us to request access to a secure route.   |  |  |  |  | | --- | --- | --- | --- | | **Southern Hub**  PHN Southern Hub  Lescaze Offices  Shinner’s Bridge  Dartington  Nr Totnes  TQ9 6JE  E:VCL.SouthernPHNhub@nhs.net  T: 03332 341901 | **Exeter Hub**  PHN Exeter Hub  Franklyn House  Franklyn Drive  Exeter  EX2 9HS  E:VCL.ExeterPHNhub@nhs.net  T: 03332 341902 | **Eastern Hub**  PHN Eastern Hub  Jerrard Wing  Honiton Hospital  Marlpits Lane  Honiton  EX14 2DE  E:VCL.EasternPHNhub@nhs.net  T: 03332 341903 | **North Until End of March 2018**  Barnstaple Health Centre  Vicarage Street  Barnstaple  EX32 7BH  E:VCL.BarnstapleHVs4Professionals@nhs.net  T: 03332 341903 | | |
| SECTION 1A **Child Information** | |
| **Name of Child or Young Person:** |  |
| **Gender:** |  |
| **Date of Birth:** |  |
| **NHS Number:** |  |
| **Child’s Address**: |  |
| **Postcode:** |  |
| **Phone Number:**  (Childs contact if appropriate) |  |
| Any known alternate family names? | Yes  No  If yes, please give details: |
| **GP Name and Practice:** |  |
| Ethnicity: |  |
| Unique Pupil Number: |  |
| (Intended) **School/educational Establishment:** |  |
| **First Language if not English:** |  |
| Interpreter required: | Yes  No |
| Religion/Belief: |  |
| Is the child/young person a carer for another family member? | Yes  No |
| **Anything known about  Legal Status:** | Child in Care/Child Subject to a Child Protection Plan/ Child under an Interim Care Order/Child under a Care Order/guardianship or other status (please describe)  Additional supporting information  (e.g. responsible placing Local authority): |
| Is there a legal plan (e.g. Supervision Order) in place? If Yes, please describe | Yes  No  Unknown |
| Reading/Writing/Comprehension within normal ranges for age:  (to help us when  communicating with the child) | Yes  No  Unknown  If no, please give details: |

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| SECTION 1B **Family Information – Parents/Carers** | | |
|  | **PRIMARY CONTACT** | **2nd CONTACT** |
| **Name:** |  |  |
| **Relationship to Child:** |  |  |
| **Address** (if different to child’s address as recorded above)**:** |  |  |
| **Post code:** |  |  |
| **Phone Number:** |  |  |
| Mobile number: |  |  |
| Email**:** |  |  |
| Known alternate Family Names**:** |  |  |
| **First Language if not English:** |  |  |
| Interpreter required: | Yes  No | Yes  No |
| **Member of Armed Forces:** | Yes  No | Yes  No |
| **Parental responsibility:** | Yes  No | Yes  No |
| Additional Supporting Information (parents/carers):  Please ensure contact details for all adults with Parental Responsibility are defined above  (and if not, please add here):  Please confirm all adults with Parental Responsibility are aware of the Request?  Yes  No | | |

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| SECTION 1C **Accessible Information**  *Please complete this section if you are making a request for yourself or as a parent/carer* | |
| Do you or your child have any special communication requirements? | You: Yes  No  Your child: Yes  No |
| Do you need a format other than standard print? | You: Yes  No  Your child: Yes  No |
| If yes, please specify: | Braille Yes  No  Large print Yes  No  Easy read Yes  No  Other, please specify |
| Do you need a British Sign Language interpreter or advocate? | You: Yes  No  Your child: Yes  No |
| Can we support you to lipread or use a hearing aid or other communication tool? | You: Yes  No  Your child: Yes  No |

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| SECTION 2 **Referral details** |
| Reason for referral to PHN Team?  What has been done to date? |

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| **Please confirm that the child/young person/family have given consent to the request for Support:**  Yes  No  Please Specify ……………………………………………………..  Consent for professional to liaise with school or early years setting yes  No  **Where a young person has given own consent, please advise whether parental agreement has also been recorded?**  Yes  No  Where the responsible adult is not aware, have all safeguarding issues been considered**?** Please comment: |

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| **Confirmation and Signatures** | |
| I confirm that every effort has been made to address this Child / Young Persons Educational, Health and/or Social Care Needs from the resources available. The Child / Young Person’s needs have now reached a nature, severity and/or complexity that require an application to be made for additional intervention. | |
| **Name of Requestor (please print):** |  |
| **Signature:** |  |
| **Role/relation to child/young person:** |  |
| **Date of Request:** |  |
| **Contact email:** |  |
| **Contact phone number:** |  |
| **Contact address:** |  |

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| Date received by PHN Team: |  | |
| Date allocated/ actioned and allocated to named professional: | |  |
| Feedback to referrer following action taken by PHN team | | |