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Health Visitor and School Nurse Referral Form – Devon (*excluding* Plymouth & Torbay)

The following information is required to ensure consistent and equitable access to Health Visitors & School Nurses, and so that decisions around accepting requests can be made quickly, with **all of the necessary information** to complete clinical screening.

Health Visitor & School Nurse support includes:

- Child & family health services delivered through the Healthy Child Programme
- Feeding advice and support
- Sleep and routines advice
- Child behaviour and development
- Toileting (Including children & young people in school)
- Adopting healthy lifestyle choices
- Young people's sexual health & relationships
- Emotional health and mental health and well-being advice
- Reducing risky behaviours (young people)
- Targeted hearing screening & managing medical conditions or health concerns in schools

Requests for support that do not include the required supporting information will be returned to the requestor for completion. Items highlighted **bold** are required fields.

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)	
GP Name and Practice:	
Religion	
Ethnicity:	
(Intended) **School/educational Establishment:**	
First Language if not English:	
Interpreter required:	Yes ☐ No ☐
Is the child subject to a legal or protective plan? e.g. Child in Care/Supervision Order/Child Protection Plan/Care Order/guardianship or other status	Yes ☐ No ☐ Not known ☐ (If yes please describe)

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SECTION 1B **Family Information – Parents/Carers**		
	PRIMARY CONTACT	**2nd CONTACT**
Name:		
Relationship to Child:		
Address (*if different* to child's)		
Post code:		
Phone Number:		
Mobile number:		
Known alternative Family Names:		
First Language if not English:		
Interpreter required:	Yes ☐ No ☐	Yes ☐ No ☐
Parental responsibility:	Yes ☐ No ☐	Yes ☐ No ☐
Additional Supporting Information (parents/carers): If adults with Parental Responsibility are not detailed above please add here:		

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SECTION 2 **Referral details**
Reason for referral to the PHN Team? (Health Visitor/School Nurse) What has been done to date? Other people/professionals involved?

SECTION 1C Additional accessible Information				
Does either the child/young person or parent have any special communication requirements?	Child/Young person: Parent	Yes ☐ Yes ☐	No ☐ No ☐	

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If yes, please specify:	Braille	Child/Young person	☐	Parent	☐
	Large print	Child/Young person	☐	Parent	☐
	Easy read	Child/Young person	☐	Parent	☐
	British sign language	Child/Young person	☐	Parent	☐
	Lip reader	Child/Young person	☐	Parent	☐
	Other communication tool, please specify				

Name of Requestor (please print):	
Signature:	
Role/ **Relationship to child/young person**	
Date of Request:	
Contact email:	
Contact phone number:	
Contact address:	

Has the child/young person/family given consent to the request for Support?

NB: If consent is not documented PHN will process this referral and will confirm consent for treatment at first contact with family/child

Yes ☐ No ☐ Please Specify ……..

Where a young person has given own consent, please advise whether parental agreement has also been recorded?

Yes ☐ No ☐

Once completed please send this form and any accompanying documentation securely to the relevant PHN HUBs below:

Exeter Hub (Exeter & Crediton)	exeterphnhub@devon.gov.uk	0333 234 1902
Southern Hub (Teignbridge, South Hams and Tavistock)	southernphnhub@devon.gov.uk	0333 234 1901

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Northern Hub (North Devon, Torridge and Okehampton)	northernphnhub@devon.gov.uk	03332 341904
Eastern Hub (East Devon, Cullompton and Tiverton)	easternphnhub@devon.gov.uk	0333 2341903

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