**ZONE 5-19 DONCASTER CHILDREN AND YOUNG PEOPLE'S HEALTH AND WELLBEING SERVICE**

**Tel: 03000218997**

**E-mail:** **rdash.doncasterchildrenscaregroup@nhs.net**

**Return to: Children's Care Group, Honeysuckle Lodge, Woodfield Park, Tickhill Road, Balby, Doncaster, Dn4 8QN**

**Website:** [**https://zone5-19.rdash.nhs.uk/**](https://zone5-19.rdash.nhs.uk/)

**Twitter: @Doncaster\_SN @zone5\_19**

**Instagram: doncasterzone5to19**

**Facebook: doncasterzone5-19**

All referrals for Zone 5-19 Doncaster Children and Young People’s Health and Wellbeing service (*previously school nursing and Project 3*) to be completed on this form

**Please note it is essential to complete as many sections as possible and ensure you have obtained parents/carers/young person’s consent**

**DATE OF CONSENT TO REFERRAL AND SHARING OF INFORMATION:………………………**

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| Referrer Name: |  |
| Address: |  |
| Tel No: |  | Email: |  |
| Contact Name: |  | Role: |  |
| **REASON FOR REFERRAL (Please tick most appropriate)** |
| **SCHOOL NURSING** | **SEXUAL HEALTH** | **SUBSTANCE MISUSE** | **STOP SMOKING**  | **CHILD EXPLOITATION** |

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| **Who has consented to the referral?** |
| Parent/Carer’s Name: |  | Relationship |  | Parental Responsibility | Yes  | No |
| Address (if different**)** | Parents/ Carers consented to referral | Yes | No |

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| **This section to be completed by the young person if appropriate.** |
| How would you like to be contacted? | Home Number: |  | Mobile Number: |  | Letter: |  | Via referring professional: |  |
| Young Persons Signature/Indicator of consent for the referral to be made. |  | Date: |  |

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| **Personal Details:** |
| **Child’s/Young Person’s Last Name** |  | **Forename(s)** |  |
| **Preferred Name** |  | Gender identity: | *Male* | *Female* | *Self-identify:* |
| **DOB** |  | Gender Assigned at Birth | *Male* | *Female* | *Self-identify:* |
| **Home Address and Postcode** |  |
| **Tel No:** |  | **Mobile:** |  |
| **School/ College (include details if mainstream, home educated, alternative education provision or not attending).****If excluded from education or training or on part time timetable, detail why.** |  |
| **Telephone/Ext** |  |
| **Additional educational support in place – GDA/EHCP/SEND plan – Please detail** |
| **Medical Information: if known** |
| **GP** |  | **Surgery / Health Centre** |  | **Telephone** |  |
| **Health: Brief details of physical or emotional health problems/difficulties. Long term health conditions. Ongoing investigations.** |
| **ALLERGIES -**  | **MEDICATION -** |
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| **Social Circumstances: Brief outline of who the child / young person lives with and details of support networks** |
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| **Child Exploitation / Safe from harm and additional vulnerabilities: Is the child / young person in contact with criminal justice services, vulnerable to sexual exploitation or criminal exploitation, frequently missing from home** |
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| **Other Agencies Involved:** (**Please provide name of keyworker/contact)****Social Services, Behaviour Support, Education Psychology, Education Welfare, Youth Offending, Children’s Centre, CAMHS, Other (please specify)** |
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| **Reason for referral area of support from Zone 5-19** Give a brief outline of the reason for the referral identifying what support is needed and any concerns you may have.  |
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| **Background Information:** Detail work that has already been completed with the young person to address the needs identified above |
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| **What does the child/young person, family, referrer want from this referral?** |
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| **Office Use:****Date referral received:****Date added to SPOC:** |