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

**Tel: 03000218997**

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**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:………………………**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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 |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 -** | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Social Circumstances: Brief outline of who the child / young person lives with and details of support networks** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **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)** |
|  |
| **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 |
|  |
| **What does the child/young person, family, referrer want from this referral?** |
|  |
| **Office Use:**  **Date referral received:**  **Date added to SPOC:** |