Staffordshire and Stoke on Trent Partnership NHS Trust

Our Health 5-19 Referral Form

Referral Criteria for Children and Young Peoples Public Health Advice and Targeted Intervention Service (Our Health5-19)

Any young person, parent/carer can contact a School Nurse directly

Primary School Age	Secondary School Age
• Continence issues e.g. soiling, enuresis • Hearing concern • Growth, over & underweight concerns • Developmental concerns • Supporting pupils & their families/carers with any newly diagnosed medical conditions • Supporting School staff when they need to produce individual health care plans for pupils • Poor attendance related to enduring illness • Health conditions that require nursing intervention • Parental advice regarding identified health needs	• Tier 1 emotional concerns *(use Tier 2 HUB if ongoing or serious concern)* • Sexual Health Issues – *including Emergency Contraception advice)* • Growth over & underweight concerns • Lifestyle concerns including smoking, drugs or alcohol • Supporting pupils & their families/carers with any newly diagnosed medical conditions • Supporting School staff when they need to produce individual health care plans for pupils • Poor attendance related to enduring illness

Please complete and return this form to the OurHealth5-19 Central Point of Access HUB via email to ourhealth5-19@nhs.net **or post to Cobridge Community Health Centre, Church Terrace, Stoke-on-Trent, ST6 2JN**

Name of Child	**Date of Birth**
Name & relationship of person with parental responsibility	**NHS Number** **(if known)** **GP**
Address	**Contact Telephone Numbers; including any mobile numbers**
School	**Class/Form/Tutor**

Reason For Referral ***(provide as much detail as possible)***
Subject to Safeguarding Plan Yes No **Looked After Child** Yes No **CAF** Yes No **Child in Need Plan** Yes No
Please list any other Agencies involved e.g. Speech & language, Parent Support Worker. Social worker etc.

Please Turn Over

PARENT/GUARDIAN /YOUNG PERSON (delete as appropriate) CONSENT TO REFERRAL

**** REFERRAL WILL NOT BE ACCEPTED UNLESS IT HAS BEEN DISCUSSED WITH & SIGNED BY PARENT/CARER FOR PRIMARY SCHOOL OR PARENT/CARER/YOUNG PERSON IF AT SECONDARY SCHOOL***

PLEASE OBTAIN

Signature of parent/guardian …….. Date ……
(primary/middle school)
OR
Young person ……..Date ……..
(high school)

I DO/DO NOT WISH FOR THE PERSON WHO HAS REFERRED MY CHILD/ME TO BE GIVEN FEEDBACK FOLLOWING ANY INTERVENTION *(Please delete as appropriate)*

Name of Referrer	**Designation**
Address for correspondence:	**Email address**
Phone number (including extension number)	**Please specify the best time to contact you.**
Signature	**Date of Referral**

For Office use only

Source of the referral	**Age of Child:**	**Date referral received and logged**
Was the referral appropriate Yes No		**Level of priority** High Medium Routine
Acknowledgement of referral within timescale Yes No		
Action taken Telephone advice ☐ Seen in School ☐ Home Visit ☐ Written advice ☐ Referral to TIS ☐ Other please state.....		
Intervention commenced within : 3 days 5 days 10 days		
Outcome letter sent to referrer Yes No		
Child/Young Persons Health Record completed YES NO		
Comments		

Name of School Nurse (print) ……..
Signature …… Date……..