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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)

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

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
Tel: **0330 024 5321**
Email: vcl.devonspa@nhs.net

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	**Exeter Hub**	**Eastern Hub**	**North** Until End of March 2018
PHN Southern Hub Lescaze Offices Shinner's Bridge Dartington Nr Totnes TQ9 6JE	PHN Exeter Hub Franklyn House Franklyn Drive Exeter EX2 9HS	PHN Eastern Hub Jerrard Wing Honiton Hospital Marlpits Lane Honiton EX14 2DE	Barnstaple Health Centre Vicarage Street Barnstaple EX32 7BH
E:VCL.SouthernPHNhub@nhs.net T: 03332 341901	E:VCL.ExeterPHNhub@nhs.net T: 03332 341902	E:VCL.EasternPHNhub@nhs.net T: 03332 341903	E:VCL.BarnstapleHVs4Professionals@nhs.net T: 01271 341500

Services provided on behalf of

Devon County Council NHS

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 ☐

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 ☐	

SECTION 2 **Referral details**

Reason for referral to PHN Team?

What has been done to date?

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:

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:	

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

Services provided on behalf of