REFERRAL TO PUBLIC HEALTH NURSING
(Health Visiting and School Nursing)

Name of Child:		**D.o.B:**	**Age:**
NHS No:	**Name of GP/Surgery:**		
Name of Parent/Carer:	**Contact Number**		
Address:			
Name of Referrer:	**Role / Agency:**		
Contact No. of Referrer:			
Pre-School /School			
Reason for Referral to PHN team:			
What has been done to date:			
Perceived PHN need/role and outcome expected from this referral:			

Consent obtained for Referral from Parent/Carer **Yes** ⬭ **No** ⬭ **(please tick as appropriate)**

Consent obtained from Child/Young Person **Yes** ⬭ **No** ⬭ **(please tick as appropriate)**

Signature of Referrer:		**Date:**	
Allocated to named Professional:		**Date:**	

PTO

Date received by PHN Team	
Date allocated/actioned	

Feedback to referrer following action taken by PHN team:

Signature:		**Date:**	
Print Name:		**Tel No:**	

Generic email: **South Hams Team**: VCL.SHamsPHNT@nhs.net

(WAP 30.10.14)