Special School Specialist Nursing Referral form

Please complete all fields; incomplete forms will have to be returned

Name:		**DOB:**	**Gender:**
NHS Number:			
Address		**Postcode:**	
Telephone:		**Mobile:**	
Email (please ensure consent is signed)			
Ethnicity:	**Religion:**	**Language:**	**Interpreter needed Y/N**
Main carer: **Relationship with child:**			
Other carers with parental responsibility: **Address if different:**			
GP Surgery:			
Does this child or the child's family pose a risk to a lone worker: ☐ **Yes** ☐**No**			
Other relevant information (cultural, social, home situation) **Parental Consent for referral:** ☐ **Yes** ☐**No**			
Diagnosis or primary area of difficulty:			

Other professionals involved	**Yes/No**
Physiotherapist	☐
Paediatrician	☐
Speech and Language Therapist	☐
Social worker	☐
Health visitor	☐
Visual Impairment Teacher or Specialist Teacher	☐
Other	☐

What are the child's difficulties? If more than one difficulty identified please state which is the primary area for initial input. ☒

Please state the reason for the referral:

What interventions (related to this issue) have been tried or are currently in place?

What was the outcome?

Please attach any relevant reports.
If previously seen by Nursing Service, when was the last contact?

Parent's level of concern about the issue for which referral is being made.

High Moderate Low

Additional views of parent / different areas of concern that they identify :

Child's views?

What is the **Desired outcome** from the Nursing assessment/intervention?

Safety
Are there any safety issues/ risks for the child or others (arising from child's needs)? Please specify:

Referrer details

Name:		Designation:	
Address:		Telephone:	

Email:			

Parental consent to share:

Share in: ☐ **Yes** ☐ **No** Share out ☐ **Yes** ☐ **No**

Please return this form with any available reports to;
Postal address: CCN Team The Peacock Centre Brookfields Campus 351 Mill Road Cambridge CB1 3DF
Electronic copy of this form can be sent to: ccs-tr.SNSN@nhs.net