**Important note to the referrer**

Consent from the person(s) with parental responsibility must be obtained prior to completing this referral, it is imperative that you, as the referrer, have explained the below to the person(s) with parental responsibility prior to the referral.

* The referral is being made to the School Nursing Service
* Person(s) with parental responsibility understands that the information gathered will be held on the NHS database and that there may be a clinical need to obtain or share information with other services inside Hillingdon Community Health and outside the School Nursing Service, in order to provide a comprehensive assessment the child/young person and for coordination of services that they may need.
* Services that information may be obtained from/shared with: General Practitioners’, Hillingdon Hospital, Other Hospitals, Early Years Provider (e.g. Nursery), Inhouse education Services (e.g. Educational Psychologist/SENCO) and Social Services (e.g. Adolescent Team, Children with learning difficulties team).

**cHILDREN AT RISK OF EXCLUSION REFERRAL**

|  |
| --- |
| Consent  |
| Has consent been obtained from the person(s) with parental responsibility prior to making this referral? If so, how? |  |
| Is the child/young person aware of this referral? |  |

|  |
| --- |
| Child/Young Persons Details |
| Family Name: | Forename: | Other name: |
| D.O.B: | Male/Female |
| Address: | Telephone Number |

|  |
| --- |
| Ethnicity |
| **White** | **Mixed** | **Asian or Asian British** | **Black or Black British** | **Other Ethnic group** |
|  🞏 British | 🞏 White & Caribbean | 🞏 Indian | 🞏 Caribbean | 🞏 Chinese |
| 🞏 Irish | 🞏White &Black African | 🞏 Pakistan | 🞏 African | 🞏White & Asian |
| 🞏 Bangladeshi | 🞏Black other *(state)* | 🞏 Asian other *(state)* | 🞏 Other (state) |  |
| Primary Language(s) spoken in the home: |  |
| Interpreter needed?  | Language:  |

|  |
| --- |
| Allocated school |
| Name of school: |  |
| On roll since: |  |
| No. of fixed term exclusions: |  |

|  |
| --- |
| Reason for referral/expectation of referrer: |
| Reason for referral / expectation of referrer / interventions attempted: |
| Parental / guardian expectation of referral:Continue overleaf if required |

|  |
| --- |
|  |

**Please send referral to our contact centre and they will forward on to the relevant school nursing team, see email below:**

cnw-tr.hillingdonchildrencc@nhs.net