## Referral to Islington School Health Team

**Child/Young Person Name: Date of Birth:**

**NHS Number (if known)**

**Parent/Guardian Name:**

**Address:**

**Postcode:**

**Telephone:**

**Email:**

**School:** **G.P:**

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Interpreter required: **No / Yes** Language required:

Is the child/young person known to any other service or already in receipt of additional support?

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| Please State: |

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**Parent/Guardian consent to referral?** Yes No

**Is the child aware of referral?**  Yes No

(If child is not aware please state why)

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**Relevant Background Information:** (e.g. Length of time problem has been an issue, poor attendance, family situation etc.)

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From the following list of services provided by school nursing can you select what you think is most relevant for this child/family:

|  |  |  |  |
| --- | --- | --- | --- |
| Bedwetting/Soiling |  | Oral health |  |
| Diet & Nutrition |  | Personal Hygiene / Body changes |  |
| Managing minor ailments |  | Healthy relationships /sexual health |  |
| Other : | | | |

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**Name of referrer:** **Designation:**

**Date of referral:** **Telephone:**

**------------------------------------------------------------------------------------------------**

**Please email the completed form to**: [whh-tr.IslSchoolNurse@nhs.net](mailto:whh-tr.IslSchoolNurse@nhs.net)

If you require further information or to discuss a referral please contact the School Health Team on: **020 3316 8021**

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#### Office use only

**Date referral received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date assigned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**