|  |
| --- |
| Our service provides universal early help and intervention to children, young people and their families on a range of health and wellbeing issues. All referrals will be triaged by a Nurse and referrals which fall outside of our service offer will not be accepted and will be returned to the referrer (Please see Connect for health’s referral criteria). Professionals, parents/carers and young people can contact the service to discuss our service offer on 03300 245 204. **Privacy Notice Statement** Please note by completing this referral, Compass will expect that:* This referral has been discussed and agreed by the service user
* You consider the service user to have capacity to give informed consent
* You have explained that any information held on this form will be stored

 by Compass on a secure databaseSigned by referrer…………………………………………………………….…………………………………………………………..………Signed by service user…………………………………………………………………………………………………………………….. (parent/carer or young person) |

**Connect for Health Referral Form**

**CONFIDENTIAL**

|  |  |  |  |
| --- | --- | --- | --- |
| Child/Young person’s Name: |   | NHS Number: |  |
| Date of Birth: |  | Gender: |  |
| Address: |  |
| Post Code: |  |
| School: |  | Year Group: |  |
| Ethnic Origin: | African |  | Bangladeshi |  | Caribbean  |  | Chinese |  |
| Indian |  | Pakistani |  | White and Asian |  | White and Black African |  |
| White and Black Caribbean |  | White British |  | White Irish |  | Other |  |
| Other Asian |  | Other Black |  | Other White |  | Other Mixed |  |
| Parent/Carer Name: |  |
| Contact Number: |  |
| Email Address: |  |
| Young Persons mobile number:(Secondary School Aged Only) |  |
| Has Consent been obtained from: | Parent/Carer |  | Young Person |  |

|  |  |
| --- | --- |
| GP Details: |  |
| Current Safeguarding Status – service user currently open to: | Early Help |  | CIN |  | CIC |  | CP |  |
| Social Worker Name |  | Next Safeguarding Meeting (Date) |  |
| Does the child/young person have any Special Educational Needs? (SEND) | Yes |  | No |  | If Yes, please advise below: |
|  |
| Does the child/young person have any disabilities? | Yes |  | No |  | If Yes, please advise below: |
|  |
| Is the child/young person currently being supported by any other professional/service? | Yes |  | No |  | If Yes, please advise below: |
|  |
| Support needed from: | School Nurses | Change Makers |
| Reason for Referral: |  |
| Referrer Name: |  |
| Designation and Organisation: |  |
| Referrer Address: |  |
| Email Address: |  |
| Contact Number: |  |
| Date of Referral: |  |
| PLEASE FORWARD YOUR COMPLETED REFERRAL FORM SECURELY |
| Connect For Health |
| Address: | Valiant Office Suites, Lumonics House, Valley Drive, Rugby CV21 1TQ.Telephone: 03300 245 204 |
| Secure emails: | connectforhealth@compass-uk.org (with an Egress account)connectforhealth@welearn365.comcompass.connectforhealth@nhs.net |