A logo with people in the middle

Description automatically generatedA logo for a nursing school

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**Connect for Health Referral Form**

**CONFIDENTIAL**

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| 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 database  Signed by referrer…………………………………………………………….…………………………………………………………..…  Signed by service user……………………………………………………………………………………………………………………..  (parent/carer or young person)  **Please note: relevant information will be shared with the child’s GP** |

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| Child/Young person’s Name: | | |  | | | | | | | | NHS Number: | | | | | | |  | | |
| Preferred Name: | | |  | | | | | | | | Birth Gender:  Preferred Gender : | | | | | | |  | | |
| Date of Birth: | | |  | | | | | | | | Preferred pronouns : | | | | | | |  | | |
| 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 1: | |  | | | | | | Parent/Carer Name 2: | | | |  | | | | | | | | |
| Contact Number: | |  | | | | | | Contact Number: | | | |  | | | | | | | | |
| Email Address: | |  | | | | | | Email Address: | | | |  | | | | | | | | |
| Consent Obtained: | | | | | | |  | Consent Obtained: | | | | | | | | | | |  | |
| Young Persons mobile number: (Secondary School Aged Only) | | | | |  | | | | | | | | | | | | | | | |
| Young Persons Email address: (Secondary School Aged Only) | | | | |  | | | | | | | | | | | | | | | |
| Has Consent been obtained from: | | | | | | | | | | | | | | Young Person | | | | |  | |

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| GP Details: | |  | | | | | | | | | | | | | | |
| Current Safeguarding Status – service user currently open to; | | Early Help | |  | | CIN | | | |  | | CIC |  | | CP |  |
| Social Worker Name | |  | | | | | Next Safeguarding Meeting | | | | | | | Date ….../….…/…….  Time ………………………… | | |
| 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: | | | | | |
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| Support needed from: School Nurses Change Makers | | | | | | | | | | | | | | | | |
| Reason for Referral: | **N/B If your referral is for support with Mental Health and Emotional Wellbeing please complete part 2 of the referral form. Please note that if the referral form is not fully completed it will be rejected at the point of receipt.** | | | | | | | | | | | | | | | |

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| Referrer Name: |  | Designation and Organisation: | |  |
| Referrer Address: |  | | | |
| Email Address: |  | Contact Number: |  | |
| Date of Referral |  | | | |
| Please tick to confirm you would like to receive family health & wellbeing updates from Connect for Health via email. | | | | |

**PLEASE FORWARD YOUR COMPLETED REFERRAL FORM SECURELY**

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| **Address:** | Connect for Health, 1 Allerton Road, Rugby, CV23 0PA  Telephone: 03300 245 204 |
| **Secure**  **Emails:** | [connectforhealth@compass-uk.org](mailto:connectforhealth@compass-uk.org) (with an egress account)  [connectforhealth@welearn365.com](mailto:connectforhealth@welearn365.com)  [compass.connectforhealth@nhs.net](mailto:compass.connectforhealth@nhs.net) |

**Part 2 – Please complete this part with the young person with as much detail as possible.**

**Mental Health and Wellbeing (MHW) Referrals into Connect for Health Service (C4H)**

***Note: If your school is part of a Mental Health Support Team (MHST) project then low level referrals should be considered for the Mental Health Lead who will then refer directly into the MHST.***

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| **Questions to be asked:** |
| Would you like support for your current difficulty?  How would you rate the level of your difficulty? **0** being no difficulty  **5** being very difficult.  Have you previously or currently receiving support for your difficulty? If yes – who was/is that with?  Is there a safe adult who could support you at home or in school? |
| **Risk Assessment** |
| **Describe the known risk:**  (Self-harm, suicidal thoughts, school refusal, low mood, anxiety, social isolation, CE.) |
| **Risk Mitigation:**  (Safety plan, given contact details of Crisis service, liaising with trusted adult, self-help tools provided, would like support, onward referral) |