**0-19 Integrated Public Health Service for Children and Young People in Derby City**

**Referral Form**

 **Please return form by email to the secure email address :** **dmh-tr.childfamily-derby@nhs.net**

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| **Young Person’s Name:** | **DOB:**  | **Gender:** |
| **Address:** **Postcode:** | **Contact Numbers:** |
| **Language spoken:** | **Interpreter required:****Yes / No** | **Ethnicity:** |
| **School/Educational Provider:** |
| **Young person aware of referral?** **Yes / No** | **Are they willing to engage?****Yes / No** | **Can the young person be contacted at home?****Yes / No** |
| **Young person’s views on referral and the outcome they would like?** |
| **Parent / Carers Name:**  | **Contact Number:**  |
| **Parent / Carer consent to referral?** **Yes / No** **If No – Please state reason why?** |

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| **Other Household members** |
| **Name** | **DOB****(if child under 19)** | **Relationship to child** | **School / Nursery** |
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| **What input has the young person received / been offered?** |
| **Services Involved with the family** |
| **Service**  | **Worker name** | **Contact info** |
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| **Service required (please select one)** |
| **School Nursing service** [ ]  | **Breakout: Drugs / Alcohol** [ ]  |
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| **Name of referrer:** **Role:** | **Contact number:** | **Date of referral:**  |
| **Reason for referral including as much detail as possible for a full assessment to be made.** |

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| **School Nursing - Reason for referral – Please specify by checking the box** |
| **Emotional health and wellbeing** [ ]  | **Please specify** **Low mood / depression** [ ] **Anger management** [ ] **Anxiety** [ ] **Self-harm** [ ] **Body image** [ ] **Other ……………………………………** |
| **Physical health** [ ]  | **Please specify****Healthy eating / Weight management** [ ] **Speech / Language** [ ] **Smoking cessation** [ ] **Toileting** [ ]  **Constipation** [ ]  **Daytime wetting** [ ]  **Night time wetting** [ ]  **Soiling** [ ] **Development concerns** [ ] **Sleep** [ ] **Audiology / Hearing**[ ] **Immunisations** [ ] **Other ……………………………………** |
| **Sexual health** [ ]  | **Please specify** **Puberty advice** [ ] **Relationships** [ ] **Contraception advice** [ ] **Sexual health advice** [ ] **Other ……………………………………** |
| **Substance use** [ ]  | **PLEASE complete drug and alcohol section below** |

**Please complete for Drug / Alcohol Referrals**

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| **Drugs/Alcohol used** | **Route (please circle)** | **Frequency (please circle)** | **Amount / Cost** | **Age of 1st use** | **YP’s perception of their substance misuse (please circle)** |
|  | **Snort, smoke, oral, inject** | **Daily, weekly, monthly, occasionally** |  |  | **Not a problem****Problem****Major problem** |
|  | **Snort, smoke, oral, inject** | **Daily, weekly, monthly, occasionally** |  |  | **Not a problem****Problem****Major problem** |
|  | **Snort, smoke, oral, inject** | **Daily, weekly, monthly, occasionally** |  |  | **Not a problem****Problem****Major problem** |
|  | **Snort, smoke, oral, inject** | **Daily, weekly, monthly, occasionally** |  |  | **Not a problem****Problem****Major problem** |

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| **Advice / Support for drugs and alcohol** |  | **Treatment for drugs and alcohol use** |  |

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| **Exclusions** |
| Speech and language concerns | If child attends school then please speak to child’s teacher who can refer direct to a speech and language therapist |
| Behaviour | If you are concerned about Autism or ADHD please refer to this website and follow the Neurodevelopmental pathway <https://derbyandderbyshireemotionalhealthandwellbeing.uk/> If concerned about behaviour consider an early help assessment which can be commenced by child’s school |
| Mental health | Please consider referral to [Building sound minds](https://services.actionforchildren.org.uk/derbyshire/build-sound-minds/), [Changing lives](https://form.jotform.com/202712608522044), CAMHs or [Kooth](https://www.kooth.com/).  |
| Bereavement | Please consider if Child or Young person needs referral to specialist service like[**treetops**](https://www.treetopshospice.org.uk/our-services/therapeutic-services/counselling-emotional-support-service/counselling-emotional-support-for-children-families/)or[**Laura’s centre**](https://thelauracentre.org.uk/) |
| Eating and body image concerns | Please consider referral to [first steps](https://firststepsed.co.uk/make-a-referral/) |
| Medical health need | If child is under the care of another professional for their medical need, please discuss concerns with them first |
| **We will not accept a referral if you are on a waiting list for another service** |

**If you experience any issues or would like to discuss your referral with a clinician, please call: 0300 123 4586 option 3(Central point of access)**