|  |
| --- |
| 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. Professionals, parents/carers and young people can contact the service to discuss our service offer on 020 3954 0091.  **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/parent/carer 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** |

**Tower Hamlets School Health Service Referral Form**

**CONFIDENTIAL**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Child/Young Person’s Name: | | |  | | | | | NHS Number: | | | | |  | | |
| Preferred Name: | | |  | | | | | Birth Gender: | | | | |  | | |
| Gender Identity: | | | | |  | | |
| Date of Birth: | | |  | | | | | 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: | | | | |  | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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? (SEN) | Yes |  | | No | |  | | | | If Yes, please advise below: | | | | | |
|  | | | | | | | | | | | | | | |
| Does the child/young person have any disabilities or long term health conditions? | 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: | | | | | | | | | | | | | | | |
| 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.** | | | | | | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 Tower Hamlets School Health Service via email. | | | | |

**PLEASE FORWARD YOUR COMPLETED REFERRAL FORM SECURELY**

|  |  |
| --- | --- |
|  | |
| **Address:** | Tower Hamlets School Health Service  Eastside Youth Centre  62 Parnell Road  London  E3 2RB |
| **Secure Email:** | [compass.towerhamletsyphws@nhs.net](mailto:compass.towerhamletsyphws@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 Tower Hamlets School Health**

***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.***

|  |
| --- |
| **Questions to be asked:** |
| Would you like support for your current difficulty?  How would you rate the level of your difficulty? **0** being not difficult and **5** being very difficult.  Have you previously/are you currently receiving support for your mental health? If yes – who was/is that with?  Is there a safe adult who can support you at home or in school? |
| **Risk Assessment** |
| **Describe the known risk:**  (Self-harm, suicidal thoughts, school attendance, low mood, anxiety, social isolation, exploitation etc.) |
| **Risk Mitigation:**  (Safety plan, given contact details of Crisis service, liaising with trusted adult, self-help tools provided, would like support, onward referral) |