



## SCHOOL NURSE REFERRAL FORM

To be completed by and returned via secure e-mail to: [schoolnurses@gov.gg](mailto:schoolnurses@gov.gg)

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Year Group: \_\_\_\_\_

Student Address: \_\_\_\_\_

Reason for referral? (eg Health Concerns, tick below and provide details):

Hearing       Toileting       Emotional wellbeing       Other

**Details of presenting issue and what has been tried before:**

**Professionals involved:** Include names, contact details and current input to date (e.g. Youth Commission, CAMHS, Speech and Language, Social Care, etc.)

Parent/carer name: \_\_\_\_\_ Tel No: \_\_\_\_\_

Have you discussed this referral with the parent/carer? Yes  No  The Student? Yes  No

Parent/carer **CONSENT** obtained? Yes  No  Do they have PR? Yes  No

Student **CONSENT** obtained? Yes  No  N/A  Yes  No

Referrer Name: \_\_\_\_\_ Role: \_\_\_\_\_ Tel No: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_