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| Bath & North East Somerset Multi Agency Referral Form |

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| **These are the services currently receiving referrals for Virgin Care Children’s Community Services.** |  | Please return this form securely by email to the individual service required.  Complete the form in full. |

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| **Details of Child**  Child's Surname: Forenames:  Date of Birth:  Family name if different to child's:  NHS No:  Ethnicity: First language:  Please tick box if interpreter is required, if yes what language:  Address:  Postcode: School / Pre-School:   **Mobile:**  Home telephone: Preferred telephone:  Child's GP:  Health Visitor/FNP Family Nurse/School Nurse (if known): |

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| **Referral to Internal Virgin Care Ltd Services**  **These are the teams currently accepting referrals using the B&NES Multidisciplinary referral form.**  Community Paediatrician Children’s Bladder & Bowel  Vcl.bathnescliniccoordinationteam@nhs.net Baneschildrensbladderandbowelservice@virgincare.co.uk  Refer to referral Pathway saved on S.Drive Refer to referral Pathway saved on S.Drive    Speech & Language Therapy (children only) Children’s Learning Disability Nursing Service  Bathnes.sltadviceline@virgincare.co.uk vcl.LDnursingbanes@nhs.net 01225 831721  Refer to referral Pathway saved on S.Drive Refer to referral guidance document on S Drive    Health Visiting School Nursing Service  Bathnes.hvadmin@virgincare.co.uk Bathnes.schoolnursing@virgincare.co.uk    Children’s Community Nurse  Banesccnservice@virgincare.co.uk |

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| **The Referrer**  Why are you making this referral?  Please give as much information as possible to enable this referral to be triaged effectively.  Continue on another sheet if needed or attach a letter.  Please send copies of additional information/reports as appropriate. |

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| **Child/young person**  What do you want to happen as a result of this referral? |

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| **Parents/Carers**  What do you want to happen as a result of this referral? |

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| |  |  |  |  | | --- | --- | --- | --- | | **About the parents/carers** | | | | | **Name** | **Relationship** | **Contact details** | **Parental Responsibility** | |  |  |  | yes no | |  |  |  | |  |  |  | yes no | |  |  |  | |  |  |  |  | |

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| **Please indicate which of these services are, or have been, involved with this child.** | | |
| Children Missing Education | Social Services | Health Visitor |
| FNP Family Nurse  Youth Offending Service | Educational Psychology    Inclusion/Learning Support | Ophthalmology  Youth Connect |
| Other (please specify): | | |

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| **For each agency currently working with the child/young person/family, please provide the following details.**  ***Use 2nd sheet if necessary.***   |  |  |  |  | | --- | --- | --- | --- | | **Start date** | **Agency** | **Name and Role** | **Tel/Mob Contact Number** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |

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| **Important; no referral can be accepted without the consent of the child or parent/guardian.** |
| Please tick at least one box.  The child or parent/guardian has consented to this referral. Child Parent/Guardian |
| I have discussed the referral fully with the child/parent/guardian as appropriate.  Discussed with GP: Yes No  Referrer’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referrer’s Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact no: ­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Other Services – send referral forms securely. See policy on JAM.**

**CAMHS**: banesreferrals@oxfordhealth.nhs.uk Please note, see specific referral form for CAMHS and referral criteria on S.Drive

**Dietician**: ruh-tr.referralsSMHdietitians@nhs.net

**Physiotherapy**: ruh-tr.childrenstherapies@nhs.net

**Audiology**: vcl.bathneswiltschildrensaudiology@nhs.net Audiology have their own referral form on the S.Drive

**Ophthalmology**: ruh-tr.orthopticreferralsruh@nhs.net

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| **Office use only** |
| Entered on system: on: |
| Referral accepted on: Referrer contacted on: |
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