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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.ukRefer 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 NurseBanesccnservice@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.***

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| **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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