Harrogate and District NHS Foundation Trust

Referral to the 0-19 Healthy Child Team

Please return form by email to: hdft.0-19darlington@nhs.net

For advice please telephone: 03000 030013

Please select the following option of either school nursing or emotional resilience nursing (for offer of each service please see below)

☐ School nursing ☐ Emotional resilience nursing

Child/Young person's name Date of birth	Address	Parent/carer telephone Number: Young persons (YP) telephone number (if appropriate):
Parent/carer name: Adult with PR: Who does the child/YP live with? Where would the child/YP like to be seen? EG. Home, in school	Next of kin if different: Relationship to child:	Has parental consent been obtained **Yes /No** If no, state why *(only in exceptional circumstances should consent not be obtained)* Has the YPs been assessed as Gillick competent? **Yes /No** Does the YP consent to this referral? **Yes /No**
School attended: Contact person. Name: Telephone number:	**Name of referrer** **Contact details of referrer:** **Email:** **Telephone:**	Is there any social work /other agency involvement? (e.g. CAMHS) **Yes/No** *If yes give details in relevant information below*

Reason for the referral to our service:

Interventions tried and/or services involved.

Anticipated outcome of referral.

Any other relevant information/ risks to lone visiting.

What we can support children and young people with.

School nursing
Toileting
Weight management
Sleep
Hygiene
Sexual health/puberty
Behaviour

Emotional resilience nursing
Anxiety/Worry
Low Mood
Self Harm
Managing Emotions
Self Esteem
Anger

Other: please state support required -

Name/ signature of referrer: Agency:	Date of referral: