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| --- | --- | --- |
| Text  Description automatically generated | Children and Young People Social Prescribing Team Referral Form |  |
| Date Of Referral: |  | Referral Via: |  |
| **Child’s Details** |
| Full name: |  | Gender assigned at birth: |  |
| Date of birth: |  | Gender identity: |  |
| Full address: |  | NHS number: |  |
| EMIS ref |  |
| Preferred language: |  |
| Ethnicity: |  |
| GP name: |  |  |
| GP practice:Please highlight relevant practice. | Pendle ValleyReedyford health care practicePendle view medical centreNelson medical practiceDr jehangir’sWhitefieldFairmore medical practice |
| Health issues, if applicable: |  |  |
| School name |  |  |
| Name of school contact and their contact number and email: |  |  |
| Referral Details |
| Please provide explanation of the reason for referral: |
| (please include any safeguarding concerns and any other services working with the family) |
| **Parent/ Guardian details** |
| Full name: |  |
| Date of birth: |  |
| Full address: |  |
| Tel: |  |
| Relationship to child: |  |
| Health issues: |  |
| Preferred language |  |
| **Who else lives in the home?** |  |
| Name, age and relationship to YP |  |
| Health issues |  |
| Name, age and relationship to YP |  |
| Health issues |  |
| Name, age and relationship to YP |  |
| Health issues |  |
| Name, age and relationship to YP |  |
| Health issues |  |
| **Referrer’s/Contact’s Details** |
| Full name: |  | Team/Agency/Organisation: |  |
| Tel: |  |
| Email: |  |
| Additional Information |
| Safe to visit alone: | Yes | No |
| If no, please state why: |  |
| Risk of infection: | Yes | No |
| If yes, please specify: |  |
| Please include additional information relevant to this referral e.g. behavioural/mental health, SEND (Inc, Pathway/referral): |
|  |

|  |
| --- |
| If You Require Feedback Please Complete |
| Full name: |  | Email: |  |
|  |  |  |  |
| **>>>>>We cannot accept a referral without consent<<<<<** |
| **Verbal consent has been obtained to share the above information with BPRCVS for referral and contact.** | **Yes** | **No** |
| **Verbal consent has been obtained to input information regarding the referral on the clients’ GP medical records.** | **Yes** | **No** |
| **Verbal consent has been obtained to discuss the information on this form with other agencies such as child’s school and children and family wellbeing if appropriate.**  | **Yes** | **No** |
| In accordance with GDPR, the data provided will be stored safely and securely in the Children & Families Team’s database and secure file storage. The purpose of this data allows the Children & Families Team to make sure we have relevant information to keep the young person safe. All records are completely confidential and only BPRCVS staff and NHS staff will have access to them. This data will be stored no longer than funder’s requirements. Agency/health practitioner referrals should direct all clients to referring and recipient organisations for a copy of their respective privacy policies and their rights as a data subjectBPRCVS Privacy Policy: Please contact a member of the Children & Families Team if you wish to receive a copy. |

Please submit the completed referral form, with consent, to both:

sammie.taylor@bprcvs.co.uk sania.farzana@bprcvs.co.uk