**Brent School Nursing Service**

clcht.brentsnspaduty@nhs.net

Tel SPA: 020 8102 4900

www.clch.nhs.uk

**REFERRAL TO THE SCHOOL NURSING SERVICE**

|  |  |  |
| --- | --- | --- |
| Name of Child: ­­­­­­­­­­­­­­ | |  |
| D.O.B: | |  |
| NHS number (if known): | |  |
| Parents/Carers Telephone contact no: | |  |
| Consent been obtained: (yes/no) | |  |
| Interpreter required (yes/no) | |  |
| *(if yes, state language)* | |  |
|  | |  |
| **Reason for Referral:** | | |
|  | | |
| Name of Referrer: |  | |
| Date of Referral: |  | |
| School: |  | |