**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:  |  |