Families' Health and Wellbeing Service Referral Form (health visiting/school nursing)

Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust

*Denotes mandatory field

Referral Criteria for Families Health and Wellbeing Service (0-19)
Any child, young person, parent or professional can contact the service directly through the Drop in's and the Hubs (details below)

• Advice and support regrading growth concerns. • Developmental concerns • Information, advice and signposting regarding health (e.g. physical, behavioural) • New to area children registering with a GP practice (families with children under 4 years) • Continence issues e.g. enuresis • Supporting pupils & their families/carers with any newly diagnosed medical conditions • Parental advice regarding identified health needs	• Emotional concerns – iThrive framework Getting advice and getting help • Advice, information and signposting regarding sexual health issues – (be aware the service does not provide Emergency Contraception) • Advice and information and signposting regarding lifestyle concerns including smoking, drugs or alcohol • Supporting school staff when they need to produce individual health care plans for pupils

Please complete and return this form to the 0-19 district HUB via email to

Families Health and Wellbeing Service (0-19)

FHWS 0-19 Hub

Anglesey House
Towers Buisness Park
Wheelhouse Road
Rugeley
WS15 1UL

(Covering all County Districts including - East Staffs, Cannock, Lichfield, Rugeley, Tamworth, Moorlands, Newcastle, South Staffordshire & Stafford)

Telephone 08081780611

Email: CaFSPA@mpft.nhs.uk

NHS Number (if known)	***Date of Birth**
***First name**	***Surname**
***Address**	*** Name & relationship of person with parental responsibility**
	***Contact details; telephone numbers including any mobile numbers and Email**
***Nursery/School**	***Class/ Form /Tutor**

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Reason For Referral ***(provide as much detail as possible including any support or interventions already provided)***					
Subject to Safeguarding Plan	Yes ☐	No ☐	Looked After Child	Yes ☐	No ☐
Early Help	Yes ☐	No ☐	Child in Need Plan	Yes ☐	No ☐
Please list any other Agencies involved e.g. Speech & language, Parent Support Worker. Social worker etc.					

Parent/guardian /young person (delete as appropriate) consent to referral

*Referral will not be accepted unless it has been discussed with & signed by parent/carer for primary school or parent/carer/young person if at secondary school

Please obtain

Signature of parent/guardian …….. **Date** enter a date.
(primary/middle school)
OR
Young person ……..Date enter a date.
(high school)

If the referral does not meet 0-19 criteria, are the family happy for us to pass it onto any other relevant agency that we deem appropriate?

Yes ☐ No ☐

Name of referrer	**Designation**
Address for correspondence:	**Email address**

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Phone number (including extension number)	**Please specify the best time to contact you.**
Signature	**Date of referral** enter a date.

The Families' Health & Well Being Service 0-19 will review and, if appropriate, send an appointment based on the information contained in this form. Please complete the referral form fully to ensure that the 0-19 service can process and respond correctly. If the form is not completed sufficiently it may be returned to the referrer.

The individual referring is responsible for ensuring consent has been gained for referral to this service and the sharing of the included information prior to completing this form.

For office use only		
Source of the referral	**Age of Child:**	**Date referral received and logged** enter a date.
Was the referral appropriate select.		**Level of priority** Select. (High/Medium/Routine)
Acknowledgement of referral within timescale Yes ☐ No ☐		
Action taken advice/information provided ☐ onward referral district team ☐ onward referral other service/agency ☐ Other please state.....		
Outcome letter required to referrer Yes ☐ No ☐		
Comments:		

Completed by (Print Name)		**Designation**	
Signature		**Date**	**22/09/2025 09:25**
		Time	