



REFERRAL - SPECIAL SCHOOL NURSING HOLIDAY SERVICE

Name: _____ DOB: _____ School: _____

Full address & Tel: _____ NHS No: _____
 PAS No: _____

GP: _____

Agencies involved:

Agency	Name	Contact details

Hypersensitivity/Allergies Known: YES (Give Details)
 NO

Diagnosis / condition: _____

Medication: _____

Areas of concern / reason for referral:

Name / sign / date: _____

Notes to follow? YES (Please see overleaf for action taken)
 No

Office use only:

Date referral received: _____ Date notes received: _____

Appropriate referral: Yes No If no, reason why: _____

