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| **Paediatric Referral Form** |

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| **Date of Issue** | **Revision Date** | **Next Planned Review Date** |
| January 2015 | November 2019 | November 2022 |
| **Document Owner** | **Approved by** | **Document number** |
| Director of Nursing and Patient Services | Senior Clinical Team | NUR-FRM-006 |

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| Referrals will only be accepted in writing and the family must be in agreement with the referral.  Please email this form to[**renniegrovehospicecare@nhs.net**](mailto:renniegrovehospicecare@nhs.net). Should you wish to discuss this referral please contact the nurse on call via our 24 hour number 01442 890444. |

**Child’s Details**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First name | |  | | | | | | Surname | | |  | | | | | | | | | | |
| Known as | |  | | | | | | Date of birth | | |  | | | | | | | | | | |
| Referral date | |  | | | | | | Referral type | | | Urgent | | |  | | Non-urgent | | | | |  |
| Male | |  | Female | | |  | | NHS number | | |  | | | | | | | | | | |
| Religion | |  | | | | | | Ethnicity | | |  | | | | | | | | | | |
| First language | |  | | | | | | Interpreter required | | | Yes | |  | | | | No | |  | | |
| Address (inc postcode) | | | | | | | | Telephone | | |  | | | | | | | | | | |
| Mobile | | |  | | | | | | | | | | |
| Email | | |  | | | | | | | | | | |
| GP Practice and address | | | | | | | | School/ Nursery | | |  | | | | | | | | | | |
| GP telephone | |  | | | | | | Health visitor | | |  | | | | | | | | | | |
| GP email | |  | | | | | | School nurse | | |  | | | | | | | | | | |
| Diagnosis | |  | | | | | | | | | | | | | | | | | | | |
| Stage of illness | |  | | | | | | | | | | | | | | | | | | | |
| Treatment received | |  | | | | | | | | | | | | | | | | | | | |
| Does the Child have any of the following? If so, please attach: | | | | | | | | | | | | | | | | | | | | | |
| Symptom management plan | | | | | Advanced care plan | | | | | | | DNACPR | | | | | | | | | |
| Yes |  | No | |  | Yes | |  | | No |  | | Yes | | |  | | | No | |  | |
| Consent received from: | | | | Young person | | | | | |  | | Parent | | | | | | | |  | |
| Consent for referral to Rennie Grove Hospice Care | | | | | | | | | | | | Yes | |  | | | | No | |  | |
| Consent for Child to receive care and treatment from Rennie Grove Hospice Care and to liaise with the GP, Consultant, other Health and Social Care Professionals and emergency services to obtain or share additional information, reports and assessments | | | | | | | | | | | | Any personal data that Rennie Grove holds will be processed in line with the current data protection legislation | | | | | | | | | |
| Yes | |  | | | | No |  | | |
| Consent to Share Information for Research which Rennie Grove are participating in | | | | | | | | | | | | This is in line with data protection and information governance regulations. | | | | | | | | | |
| Yes | | |  | | | No | |  | |
| Relevant / past medical history: | | | | | | | | | | | | | | | | | | | | | |

**Family Details (Mother/ Father/ Relevant person)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Who has Parental Responsibility? | |  | | | |
| Full Name |  | Relationship to Child | |  | |
| Date of Birth |  | Parental Responsibility | |  | |
| Address (inc postcode) |  | Ethnicity | |  | |
| Religion | |  | |
| First language | |  | |
| Telephone |  | Interpreter Required? | |  | |
| Mobile |  | Other phone | |  | |
|  |  |  | |  | |
| Full Name |  | Relationship to Child | |  | |
| Date of Birth |  | Parental Responsibility | |  | |
| Address (inc postcode) |  | Ethnicity | |  | |
| Religion | |  | |
| First language | |  | |
| Telephone |  | Interpreter Required? | |  | |
| Mobile |  | Other phone | |  | |
|  |  |  | |  | |
| Sibling name |  | DOB |  | Gender |  |
| Sibling name |  | DOB |  | Gender |  |
| Sibling name |  | DOB |  | Gender |  |
| Sibling name |  | DOB |  | Gender |  |
| Sibling name |  | DOB |  | Gender |  |

**Other Professionals Involved**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Professional | Name | Address | | Telephone | | | Email | |
| Consultant 1 |  |  | |  | | |  | |
| Consultant 2 |  |  | |  | | |  | |
| Social worker |  |  | |  | | |  | |
| Health visitor |  |  | |  | | |  | |
| Community nurse |  |  | |  | | |  | |
| Physiotherapist |  |  | |  | | |  | |
| OT |  |  | |  | | |  | |
| Local hospital |  |  | |  | | |  | |
|  | | | | | | | | |
| Is the child subject to a Child Protection Plan? | | | | Yes | |  | No |  |
| Details or any other relevant information: | | | | | | | | |
| **Reason for referral?** | | | | | | | | |
| Symptom management | | |  | | Response required in: | | | |
| End of life care | | |  | | 24 hours | | |  |
| Emotional / psychological support | | |  | | 3 working days | | |  |
| Respite | | |  | | 1 working week | | |  |
| Support | | |  | | Other (specify) | | |  |

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| Patient is currently at: | Home | |  | Hospital |  | Hospice |  | Other - specify |  |
| Referrers name |  | | | | | Job title | |  | |
| Referrers contact details | | Phone | |  | | Email | |  | |

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| For RGHC use only - Outcome: | Accepted |  | Not Accepted |  | Declined by family |  |
| Telephone contact made on: | | | | | | |
| 1st Visit: | | | | | | |
| Additional comments: | | | | | | |

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| **Change Control** | | | | |
| **Version** | **Date of**  **Change** | **Changed By** | **Teams**  **Consulted** | **Brief Description of updates** |
| 2.0 | 29/11/19 | Paed Team Manager | Governance | New template |