

Care referral Form B Page 1 of 7

To be completed by parent, carer or professional



If this is an urgent, fast track referral, please call the relevant hospice,

ordinarily this is the hospice closest to the child's home address, Little Bridge House in Devon 01271 321 999, Charlton Farm in North Somerset 01275 866 611, Little Harbour in Cornwall 01726 65 555. Otherwise please complete the form below in BLOCK CAPITALS and together with the completed Parent or carer consent (form A), return to: Care Team Admin, Children's Hospice South West (head office), Little Bridge House, Redlands Road, Fremington, Barnstaple EX31 2PZ or email: careteam.lbh@chsw.org.uk

Details of child/young person

Is the child/young person aware of this referral: Yes No

| | |
|-----------------|--------------------------------------------------------------------------------|
| First name: | Surname: |
| Known as: | Date of birth: |
| Address: | Gender: |
| | Ethnic group, (if known): |
| Postcode: | Religion, (if known): |
| First language: | Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No |

Nursery/school/college (if applicable):

Integrated Care Board (ICB), (if known):

Main diagnosis/reason for referral:



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To be completed by parent, carer or professional

Parent or carer 1 Parental responsibility: Yes No

| | |
|--------------------------|--------------------------------------------------------------------------------|
| First name: | Surname: |
| Address: | Relationship to child: |
| | Home tel: |
| Postcode: | Mobile tel: |
| Email: | |
| First language: | Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Additional/health needs: | |

Parent or carer 2 Parental responsibility: Yes No

| | |
|--------------------------|--------------------------------------------------------------------------------|
| First name: | Surname: |
| Address: | Relationship to child: |
| | Home tel: |
| Postcode: | Mobile tel: |
| Email: | |
| First language: | Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Additional/health needs: | |

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To be completed by parent, carer or professional

Sibling 1

| | |
|-------------------------------------|--------------------------|
| First name: | Surname: |
| Address (if different to overleaf): | Date of birth: |
| | Gender: |
| Postcode: | Additional/health needs: |

Sibling 2

| | |
|-------------------------------------|--------------------------|
| First name: | Surname: |
| Address (if different to overleaf): | Date of birth: |
| | Gender: |
| Postcode: | Additional/health needs: |

Sibling 3

| | |
|-------------------------------------|--------------------------|
| First name: | Surname: |
| Address (if different to overleaf): | Date of birth: |
| | Gender: |
| Postcode: | Additional/health needs: |

Sibling 4

| | |
|-------------------------------------|--------------------------|
| First name: | Surname: |
| Address (if different to overleaf): | Date of birth: |
| | Gender: |
| Postcode: | Additional/health needs: |

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About the child/young person

An opportunity to explain what the child struggles with, or needs help with on a day-to-day basis to help us understand their needs.

Medical, nursing or social needs:

Feeding (tick all applicable): Oral NG PEG PEJ TPN

Do they have seizures? Yes No

Breathing difficulties or support (tick all applicable):

None Tracheostomy Oxygen BiPAP CPAP Airvo Ventilation Other

Details if appropriate:

How do they mobilise (tick all applicable or provide brief description):

Independent Walking aids Wheelchair Hoist

Details if appropriate:

How do they communicate?

What is the child/young person's understanding of their condition and prognosis?

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Professionals involved

Does the child have a social worker and/or disability social worker? Yes No
If yes, please include details in 'Other professionals area'

Are there any safeguarding needs, such as a child protection plan in place? Yes No

GP

GP name:

Address:

Practice:

Tel:

Postcode:

Email:

Lead Consultant

Lead Consultant:

Address:

Speciality:

Tel:

Postcode:

Email:

Other Professional

Name:

Address:

Professional role:

Tel:

Postcode:

Email:

Other Professional

Name:

Address:

Professional role:

Tel:

Postcode:

Email:

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To be completed by parent, carer or professional

Other Professional

| | |
|--------------------|-----------|
| Name: | Address: |
| Professional role: | |
| Tel: | Postcode: |
| Email: | |

Other Professional

| | |
|--------------------|-----------|
| Name: | Address: |
| Professional role: | |
| Tel: | Postcode: |
| Email: | |

Other Professional

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|--------------------|-----------|
| Name: | Address: |
| Professional role: | |
| Tel: | Postcode: |
| Email: | |

Other Professional

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|--------------------|-----------|
| Name: | Address: |
| Professional role: | |
| Tel: | Postcode: |
| Email: | |

Other Professional

| | |
|--------------------|-----------|
| Name: | Address: |
| Professional role: | |
| Tel: | Postcode: |
| Email: | |

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To be completed by parent, carer or professional

Any other relevant information:

Referrer's details

First name:

Surname:

Address:

Relationship to child:

Home tel:

Postcode:

Mobile tel:

Email:

Signature:

Date:

Please send this completed the form together with the completed Parent or carer consent (form A) to:
Care Team Admin, Children's Hospice South West (head office), Little Bridge House, Redlands Road, Fremington,
Barnstaple EX31 2PZ or email: careteam.lbh@chsw.org.uk

Has Form C been requested via the Lead Paediatrician? Yes No