Medical referral

children's hospice SOUTH WEST

To be completed by Lead Paediatrician

In order to prevent delay in accessing services for the child/young person, please return this form as soon as possible. We regret that a referral cannot be considered until this form has been received.

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 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 Please note, Parent or carer consent (form A) and Care referral (form B) will also need to have been received for the referral to be considered

Details of child/young person

Is the parent/carer aware of this referral: ☐ Yes ☐ No

First name:	Address:
Surname:	
Date of birth:	
NHS number:	Postcode:
Parent name:	Parent mobile tel:
Parent email:	

Medical details

Addition of latest clinic letter may be used as alternative for this section

Diagnosis/problem list:

Medications:

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Seizures

For children/young people with seizures, please provide further information below, and/or attach relevant seizure plan

Please provide details on the types and frequency of seizure that the child suffers with:

Hospital admissions

Has the child ever been admitted to HDU/ITU? ☐ Yes ☐ No

If yes please give details:

Has the child had any other significant/prolonged hospital stays? ☐ Yes ☐ No

If yes please give details:

How many hospital admissions has the child had in the past 12 months?

Is there any planned upcoming major surgery? ☐ Yes ☐ No

If yes please give details:

Prognosis

Do you expect the child to live to 18 years? ☐ Yes ☐ No

Would you be surprised if this child dies before their 18th birthday? ☐ Yes ☐ No

Likely prognosis (and reason for answer):

Parents/carers understanding of prognosis:

Child/young person's understanding of prognosis:

Are any of the following in place (if yes please include)

Advanced care plan/wishes document ☐ Yes ☐ No Symptom management/escalation plan ☐ Yes ☐ No

Resuscitation plan ☐ Yes ☐ No

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Vulnerability factors (adjusted from Helen and Douglas House)

Which of these factors apply? They are particularly relevant to children and young people in the ACT 4 category – (neurological disability, - for instance cerebral palsy) but please answer for all referrals.

Children and young people who are likely to be accepted for Children's Hospice services and to benefit most from specialist palliative care would have orange/red features in more than one category, although each child will be considered on an individual basis.

Respiratory

- ☐ Two plus chest infections requiring hospitalisation per year
- ☐ Vulnerable airway
- ☐ PICU admission for lower respiratory tract infection
- ☐ Scoliosis impacting on respiratory function
- ☐ Apnoeas requiring intervention
- ☐ Requirement for long term oxygen therapy or NIV at home
- ☐ Tracheostomy and/or 24-hour ventilation

Neurological

- ☐ Epileptic activity needing medication
- ☐ Poor seizure control despite numerous drugs
- ☐ Frequent use of seizure rescue medication (daily basis)
- ☐ Episodes of status epilepticus requiring intensive treatment (IV infusions/PICU)

Gastrointestinal

- ☐ Gastrostomy
- ☐ Jejenostomy
- ☐ Severe uncontrolled reflux despite maximal treatment
- ☐ Pain/distress associated with feeding necessitation progressive feeding reduction
- ☐ Severe gut failure requiring TPN

Locomotor

- ☐ Spastic quadriplegia/total body involvement
- ☐ Poor head control/fixed spinal curvature
- ☐ Dependent on wheelchair driven by a carer
- ☐ Difficulty in maintaining a sitting position (Gross Motor Function Classification System Level V)

Other system failure

- ☐ Organ failure awaiting transplant
- ☐ Unstable cardiac condition awaiting surgery

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Any other relevant information:

Referrer's details

First name:	Address:
Surname:	
Relationship to child:	
Tel:	Postcode:
Email:	
Signature:	Date:

Please send this completed form 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

Please note, Parent or carer consent (form A) and Care referral (form B) will also need to have been received for the referral to be considered

If you are uncertain as to whether to proceed at this time and wish to discuss this referral first, please call 01271 321 999