Referral (Form B)

children's hospice SOUTH WEST

If this is an urgent, fast track referral, please call 01271 321 999

Complete the form below in BLOCK CAPITALS and together with the completed Parent 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.chsw@nhs.net

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: ☐ Yes ☐ No

Nursery/school/college (if applicable):

Clinical Commissioning Group (CCG), (if known):

Main diagnosis/reason for referral

Referral (Form B)

Carer 1

First name:

Surname:

Address (if different to overleaf):

Relationship to child:

Parental responsibility: ☐ Yes ☐ No

Home tel:

Postcode:

Mobile tel:

Email:

First language:

Interpreter required: ☐ Yes ☐ No

Health needs:

Carer 2

First name:

Surname:

Address (if different to overleaf):

Relationship to child:

Parental responsibility: ☐ Yes ☐ No

Home tel:

Postcode:

Mobile tel:

Email:

First language:

Interpreter required: ☐ Yes ☐ No

Health needs:

Referral (Form B)

Sibling 1

First name:

Surname:

Address (if different to overleaf):

Date of birth:

Gender:

Additional/health needs:

Postcode:

Sibling 2

First name:

Surname:

Address (if different to overleaf):

Date of birth:

Gender:

Additional/health needs:

Postcode:

Sibling 3

First name:

Surname:

Address (if different to overleaf):

Date of birth:

Gender:

Additional/health needs:

Postcode:

Sibling 4

First name:

Surname:

Address (if different to overleaf):

Date of birth:

Gender:

Additional/health needs:

Postcode:

Referral (Form B)

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?

Referral (Form B)

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:

Practice:

Address:

Tel:

Postcode:

Email:

Lead Consultant

Lead Consultant:

Speciality:

Address:

Tel:

Postcode:

Email:

Other Professional

Name:

Professional role:

Address:

Tel:

Postcode:

Email:

Other Professional

Name:

Professional role:

Address:

Tel:

Postcode:

Email:

Referral (Form B)

Other Professional

Name:

Professional role:

Address:

Tel:

Postcode:

Email:

Other Professional

Name:

Professional role:

Address:

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Postcode:

Email:

Other Professional

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Professional role:

Address:

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Postcode:

Email:

Other Professional

Name:

Professional role:

Address:

Tel:

Postcode:

Email:

Other Professional

Name:

Professional role:

Address:

Tel:

Postcode:

Email:

Referral (Form B)

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 consent (Form A) to:
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Has Form C been requested via the Lead Paediatrician? ☐ Yes ☐ No