

# Medical referral (Form C)

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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 01271 321 999

Please complete the form below in BLOCK CAPITALS providing as much information as possible 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.chsw@nhs.net](mailto:careteam.chsw@nhs.net)

## 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 this child to live beyond 18 years?  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

## Vulnerability factors (adjusted from Helen and Douglas House)

Which of the factors apply, these 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
<input type="checkbox"/> Two plus chest infections requiring hospitalisation per year
<input type="checkbox"/> Vulnerable airway
<input type="checkbox"/> PICU admission for lower respiratory tract infection
<input type="checkbox"/> Scoliosis impacting on respiratory function
<input type="checkbox"/> Apnoeas requiring intervention
<input type="checkbox"/> Requirement for long term oxygen therapy or NIV at home
<input type="checkbox"/> Tracheostomy and/or 24-hour ventilation
Neurological
<input type="checkbox"/> Epileptic activity needing medication
<input type="checkbox"/> Poor seizure control despite numerous drugs
<input type="checkbox"/> Frequent use of seizure rescue medication (daily basis)
<input type="checkbox"/> Episodes of status epilepticus requiring intensive treatment (IV infusions/PICU)
Gastrointestinal
<input type="checkbox"/> Gastrostomy
<input type="checkbox"/> Jejunostomy
<input type="checkbox"/> Severe uncontrolled reflux despite maximal treatment
<input type="checkbox"/> Pain/distress associated with feeding necessitating progressive feeding reduction
<input type="checkbox"/> Severe gut failure requiring TPN
Locomotor
<input type="checkbox"/> Spastic quadriplegia/total body involvement
<input type="checkbox"/> Poor head control/fixed spinal curvature
<input type="checkbox"/> Dependent on wheelchair driven by a carer
<input type="checkbox"/> Difficulty in maintaining a sitting position (Gross Motor Function Classification System Level V)
Other system failure
<input type="checkbox"/> Organ failure awaiting transplant
<input type="checkbox"/> 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.chsw@nhs.net](mailto:careteam.chsw@nhs.net)

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

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