**REFERRAL** **FORM**

|  |  |  |
| --- | --- | --- |
| **Date/Time:**  |  | **ick box if "yes" below)** |
| Triage: Please tick appropriate box(s) below: |
| Urgent [ ]  (2-4hrs) | Routine [ ]   |
| Consent: |
| **Does the patient/carer consent to this referral ?** |  YES [ ]  NO [ ]  |
| **Patient Details:** |
| **Patient Name:** **Likes to be called:**  | NHS No:  |  |
| Gender:  |  |
| DoB:  |  |
| Age:  |  |
| **Lives with:** | Ethnicity:  |  |
| Religion: |  |
| First Language: |  |
| **Safeguarding Concerns**(If yes please give details) |  |
| Parent/Carers Details  |
| Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Next of Kin: YES/NOParental Responsibility: |  |
| Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Next of Kin: YES/NOParental Responsibility: |
| **List Sibling Names and Dates of Birth, if applicable:** |
| **NAME** | **Date of Birth or Age** |
|  |  |
| **Patient Medical Information:** |
| **Primary Diagnosis of Patient:****Presenting Condition of Patient:** |
|  | **Yes: Further details** | No |
| Are there any allergies? |  |  |
| Does the patient have a palliative diagnosis? |  |  |
| Does the patient have a DNACPR in place? |  |  |
| Does the patient have a ReSPECT form? |  |  |
| Has an Advance Care Plan ( ACP) been completed? |  |  |
| Are anticipatory medications prescribed? |  |  |
| Are there any communication problems? |  |  |
| REFERRAL CRITERIA |
|  **Groups 4:** Irreversible but non-progressive conditions that cause severe disability, leading to susceptibility to health complications and likelihood of premature death.*Examples: severe multiple disabilities such as following brain or spinal cord injuries.*NB: We appreciate this group of children are very complex in nature and can be deemed as vulnerable. In addition, the definition is broad, unclear and can be open to interpretation. As a multi-disciplinary team, we assess each individual child on their specific health needs and may come to the decision that the child may not fit the Hospice criteria at the time of referral or subsequent reviews**Groups 1:** Life-threatening conditions for which curative treatment may be feasible but can fail. Palliative care may be necessary during periods of prognostic uncertainty and when treatment fails. Children in long-term remission or following successful curative treatment are not included.*Examples: cancer, irreversible organ failures of heart, liver, kidney*.**Groups 3:** Progressive conditions without curative treatment options, where treatment is exclusively palliative and may commonly extend over many years.*Examples: Batten’s disease, mucopolysaccaridosis.***Groups 2:** Conditions where there may be long periods of intensive treatment aimed at prolonging life and allowing participation in normal childhood activities, but premature death is still possible.*Examples: cystic fibrosis, muscular dystrophy.***\* GROUP 4 ONLY \*** please indicate most relevant point on the scale that child/young person is at in relation to following vulnerability factors and any additional factors:**Low:** **Respitory Factors** **High:**

|  |  |  |  |
| --- | --- | --- | --- |
| Frequent or increasing number of lower respiratory infections [ ]  | PICU admission/multiple admissions, chest infections [ ]  | Requirement for long term oxygen at home or long term ventilation [ ]  | Tracheostomy and/or24hr ventilation [ ]  |

 **Nutrition Factors**

|  |  |  |  |
| --- | --- | --- | --- |
| Bullbar palsy affecting feeding [ ]  | Aspiration Severe reflux [ ]  | Loss of weight [ ]  | Pain/distress associated with feeding, causing progressive feed reduction [ ]  |

 **Neurology Factors**

|  |  |  |
| --- | --- | --- |
| Seizures/spasms/movement disorder requiring medication [ ]  | Significant/escalating pain and distress due to muscle spasm, postural control or seizures [ ]  | Episodes of status epilepticus requiring frequent hospital admissions/intensive treatment (IV infusions/PICU) [ ]  |

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| Please tick which service you would like your referral to be forwarded to:  |
| Andy’s Children’s Services [ ]  Family Support and Spiritual Care [ ]    |
| **Reason for Referral: Please provide additional information** |
| **Physical/Symptom Management:** |  |
| **Psychological/Emotional:** |  |
| **Religious/Spiritual:** |  |
| **End of Life Care:** |  |
| **Hospice At Home** |  |
| **Children’s Wellbeing Service:** |  |
| **Respite:** |  |
| **Additional Information** Please give all relevant information to support this referral |
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| **GP & Consultant Contact Details:** |
| **GP Name:**Practice:Contact Number: | Consultant Name:Job Title:Address:Contact Number:Email: | Consultant Name:Job Title:Address:Contact Number:Email:  | Consultant Name:Job Title:Address:Contact Number:Email:  |
| Name:Job Title:Address:Contact Number:Email: | Name:Job Title:Address:Contact Number:Email: | Name:Job Title:Address:Contact Number:Email: | Name:Job Title:Address:Contact Number:Email: |

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| Initial Home Risk Assessment: |
| How many adults/children live in the home with the patient? | Are there any pets in the home?  |
| Are there any noticeable hazards e.g. parking difficulties/street lighting/smokers within the home etc? YES [ ]  NO [ ] If yes, please provide details: |

|  |
| --- |
| **Referrer Details:** |
| Name: Address: Postcode:Main Contact Number:  | Please state the relationship to the patient or your professional role? |

|  |
| --- |
| Completed by: |
| Name |  | Date & Time | Position Held | Main Contact Number |
|  |  |  |  |

Please email completed referral to SAHOS.SeniorAdmin@nhs.net