

Care Referral Form

Referral type: routine urgent symptom control end of life

Child's details

Surname: _____

First name(s): _____

Date of Birth: _____

Gender: Male

Female

NHS Number: _____

Home address: _____

Post Code: _____

Telephone numbers: _____

Email: _____

Religion: _____

Ethnic Group: _____

First Language: _____

Nursery, school or college attended: _____

CCG: _____

Diagnosis:

Diagnostic key:

Carer's details

Carer 1: Parental Responsibility

Carer 2: Parental Responsibility

Name: _____

Name: _____

Relationship to child: _____

Relationship to child: _____

First language: _____

First language: _____

Interpreter required: Yes No

Interpreter required: Yes No

Address (if different to above): _____

Address (if different to above): _____

Ethnic group: _____

Ethnic group: _____

Health Needs: _____

Health Needs: _____

Siblings

Name	Male/Female	DoB	Health needs
1			
2			
3			
4			
5			
6			

Professional involvement – medical

General Practitioner (GP):

Practice address

Post Code:

Telephone:

Consultant 1

Hospital address

Consultant 2

Hospital address

Telephone:

Telephone:

Consultant 3

Hospital address

Consultant 4

Hospital address

Telephone:

Telephone:

Professional involvement – allied professionals

e.g. health visitor, school nurse, children's community nurse, social worker, physiotherapist, speech and language therapist

Name

Title/Role

Telephone

1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Nursing, social and medical history

Please continue on a separate sheet if necessary

Current treatment

Please continue on a separate sheet if necessary

Child's understanding of their diagnosis and prognosis

Details of regular family support

Other short breaks or community support

Consent

Have the child's parents (or those with parental responsibility) consented to the referral?

Yes

No

Has the young person consented to the referral? (if applicable)

Yes

No

Referrer

Name _____

Relationship to child/job title: _____

Contact number: _____

Email address: _____

Date: _____

Referral taken by: _____

Signed: _____

FOR OFFICE USE ONLY	Form received:	Family contacted:	Consent:	Signature:
	Letter to GP:	Letter to consultant:	On Computer:	Signature:
	Accepted/Not Accepted:	Died before admission:	On Computer:	Signature:
	Do not wish to use us at present:	Signature:	Now wish to use us:	Signature:
	Review date: NA <input type="checkbox"/>	Review date: NA <input type="checkbox"/>	Review date: NA <input type="checkbox"/>	Review date: NA <input type="checkbox"/>
	Re-referred:	Accepted/Not Accepted	On Computer:	Signature:
	Date of Death:	Place of Death:	On Computer:	Signature:
	No longer involved:		On Computer:	Signature: