**CHILDREN'S TEAM REFERRAL FORM**

**THIS FORM MUST BE COMPLETED AND RETURNED WITH SIGNED CONSENT FROM PARENT/CARER WITH PARENTAL RESPONSIBILITY BEFORE WE CAN ACCEPT THE REFERRAL**

**Patient Demographics:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Child’s Name: |  | | | DOB: |  | |
| Tel No: |  | | | Age: |  | Male/Female |
| Family Address:  Postcode: |  | | | | | |
| Email: |  | | | | | |
| Hospital number: |  | NHS No: |  | | | |
| Ethnic Origin: |  | Religion |  | | | |

**CONSENT**

**FOR THOSE UNABLE TO CONSENT AND CHILDEN UNDER 16**

Has the parent given consent for the referral and for us to seek & share health and social care information?

Yes  No

**FOR YOUNG PEOPLE AGED 16 AND OVER WITH CAPACITY TO CONSENT**

has the young person given consent for the referral and for us to seek & share health and social care information?

Yes  No

**Please note that it may be necessary for us to request further medical information to proceed with the referral.**

**REFERRAL CRITERIA**

The team support children and their families who fit into one of these four categories:

Please tick which category applies.

1. Disease for which curative treatment may be feasible but may fail. (E.g. cancer, organ failure)
2. Diseases in which premature death is anticipated but intensive treatment prolongs good quality

life (e.g. Cystic Fibrosis, HIV, AIDS)

1. Progressive diseases for which treatment is exclusively palliative and may extend over many

years (e.g. Battens Disease, Mucopolysaccharidoses)

1. Conditions with severe neurological disability that, although not progressive, lead to vulnerability

and complications likely to cause premature death (e.g. severe cerebral palsy and brain damage) \*

**Children who fit into groups one, two & three have automatic acceptance into our service.**

**Children in group four will be assessed with additional criteria on referral.**

**Reason for referral:**

Acute Oncology Care

Symptom Management

Support with co-ordinating and managing complex palliative diagnosis

Respite Care

End of Life Care

Advanced Care Planning

**Diagnosis and Past Medical History**:

**Current Concerns / Symptoms:**

**Parent’s/patient’s understanding of diagnosis, prognosis and need for palliative care involvement:**

**ACP in place?** YES / NO **SMP in place?** YES / NO

**Please give details of any safeguarding concerns below:**

**Professionals involved:**

|  |  |  |
| --- | --- | --- |
| **Role** | **Name** | **Contact Details** |
| GP |  |  |
| Lead Consultant Specialist |  |  |
| Community Consultant |  |  |
| Social Worker |  |  |
| Community Nursing Team |  |  |
| School |  |  |
| Palliative Care Team |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Parents / Carers Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Last Name** | **First Name** | **Title** | **DOB** | **Relationship to the Child** | **Parental Responsibility** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Address (if different from one stated above): | | | | | |

**Sibling Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full name** | **DOB** | **Sex** | **Health Needs** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Referral made by:**

|  |  |
| --- | --- |
| Name: | Position: |
| Address: | Telephone No: |
| Date: |