**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** |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |

**Referral made by:**

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