ellenor
TEL: 01474 320007
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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) ☐

3) Progressive diseases for which treatment is exclusively palliative and may extend over many years (e.g. Battens Disease, Mucopolysaccharidoses) ☐

4) 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.

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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

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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		

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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: