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**care referral form**

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| **Please note that referrals can also be made by telephoning the care team on 01484 411042 or by fax to 01484 502 251 or sending a letter addressed to Director of Care**  |

**Child’s details**

Surname: .……………………………………………………………………First Name: …………………………………………………………………………

Date of Birth: ……………………………………………………………………… Gender: Male Female

NHS Number: ……………………………………………………………………..

Home Address:­­­­­­­­­­­­­ …………………………………………………………………………………………………………………………………………………..

 ………………………………………………………………………………..Postcode: ………….………………......................

Home Telephone Number: ………………………………………………………….

Mother’s Mobile Number: ………………………………………………… Father’s Mobile Number: ……………………………….…………….

First Language: …………………………………………………………………………..

Nursery, School or college attended: ……………………………………………………………………………………………………………………………

**Diagnosis:**

**Ethnic Group (Mandatory)**

White English/Welsh/Scottish/Northern Irish/British

 Irish Gypsy or Irish Traveller

 Any other White background (please specify)

Mixed Multiple Ethnic Groups White and Black Caribbean White and Black African

 White and Asian

 Any other mixed/multiple ethnic background (please specify)

­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­Asian or Asian British Indian Pakistani

 Bangladeshi Chinese

 Any other Asian background (please specify)

Black/African/Caribbean/Black British African Caribbean

 Any other Black/African/Caribbean background (please specify)

Other Ethnic Group Arab

 Any other ethnic group (please specify)

**Parent Details**:

Carer 1: Parental responsibility? (please tick) Carer 2: Parental responsibility? (please tick)

Name: …………………………………………………………………………. Name: ………….…..…………………..………………………………..……

Date of Birth: ………………………………………………………………. Date of Birth: ………………………………………………………………..

Relationship to child: ………………………………………………….. Relationship to child: …………………………………………………….

First Language: …………………………………………………………… First Language: ………………………………………………………………

Interpreter Required? ………………………………………………….. Interpreter Required? ……………………………………………………

Address *(if different to above)* Address *(if different to above)*

Ethnic Group/Religion if different from above: ……………………………………………………………………………………………………………

Does this child currently receive care/support from another children’s hospice? Yes  No  if yes please indicate whom and the date referred…………………………………………………………………………………………………………………………………………

Has this child ever been declined by a palliative care service? Yes  No ****

**Siblings**:

Name: Male/Female DOB Health Needs

1. …………………………………………………………………………………………………………………………………………………………………………………

2. …………………………………………………………………………………………………………………………………………………………………………………

3. …………………………………………………………………………………………………………………………………………………………………………………

4. …………………………………………………………………………………………………………………………………………………………………………………

5. …………………………………………………………………………………………………………………………………………………………………………………

6. …………………………………………………………………………………………………………………………………………………………………………………

**Professional Involvement – Medical**

**General Practitioner (GP**) …………………………………………………………………………………………………………………………………………….

Practice address: ………………………………………………………………………………………………………………………………………………………....

……………………………………………………………………………………………………Postcode: …………………………………………

Telephone: ……………………………………………………………………………… Fax: ………………………………………………….

**Consultant 1:** …………………………………………………………………………… Title/area of practice……………………………………………….

Hospital: …………………………………………………………………………………. Telephone: ……………………………………………………………

**Consultant 2:** …………………………………………………………………………… Title/area of practice………………………………………….……

Hospital: …………………………………………………………………………………. Telephone: ……………………………………………………………

**Consultant 3:** …………………………………………………………………………… Title/area of practice………………………………………….……

Hospital: …………………………………………………………………………………. Telephone: ……………………………………………………………

**Professional Involvement – Others**

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.** |  |  |

**Full medical background**

**Please continue on a separate sheet if necessary**

**Current medical treatment**

**Please continue on a separate sheet if necessary**

**MANDATORY – PLEASE FILL IN ALL SECTIONS ON THIS PAGE**

**Current family situation and additional supporting information**

**What help is the family looking for from the Forget Me Not Children’s Hospice?**

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..............

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

**Yes No**

Forget Me Not Children’s Hospice will use the information provided on this form in order to process the referral, and determine how best we can support the child and family. Information will also be used to ensure we are providing the safest and most effective treatment for the child and family. Information will be securely held on our systems, and only held for as long as we have a legitimate reason for. For full details on how this information will be used, please visit our website (<https://www.forgetmenotchild.co.uk/clinical-privacy>) to view a copy of our Privacy Policy. You can also contact us on 01484 411040, or write to us using the address at the bottom of the page.

**In order to ensure that we have access to the most accurate treatment and medical information, we would like to contact the professionals involved in caring for the child – such as GP’s and consultant paediatricians. Information collected will only be used by Forget Me Not Children’s Hospice for the purposes of providing care, support and treatment, and you can change your preferences at any time by contacting us. Likewise, if you only provide consent for us contacting one organisation (such as the GP), please indicate this below.**

Can we contact your child’s GP, consultant and other professionals for more medical information?

Yes No

*If you only wish us to contact one organisation (such as the GP), please indicate here: ……………………………………………*

Who would be the appropriate consultant to approach? …………………………………………………………………………………………

Is the child subject to any Safeguarding plans? Yes No

Any additional information

**To help Forget Me Not make an informed decision are there any known risks within the family’s home environment: Please tick appropriate box:**

 **No known history of violence, alcohol, drug abuse within the home environment.**

 **Current knowledge of violence, alcohol/drug abuse within the home environment.**

 **Knowledge of previous violence, alcohol, drug abuse within the home environment.**

**Referrer**

Name: ………………………………………………………………………… Relationship to child/job title: ………………………………………….

Telephone Number: …………………………………………………… Mobile Number: ……………………………………………………………..

Email Address: …………………………………………………………………………………………………………………………………………………………….

Signature: ………………………………………………………………….. Date: ……………………………………………………………………………….

**Please return this form to: Sharon Burton, Director of Care, Forget Me Not Children’s Hospice, Russell House, Fell Greave Road, Huddersfield, HD2 1NH Tel: 01484 411042 Fax: 01484 502251**

**Please help us develop our service: How did you hear about us?**

|  |  |  |  |
| --- | --- | --- | --- |
| **A professional / colleague** |  | **Friend or family** |  |
| **FMNCH Website** |  | **Social Media (Facebook etc)** |  |
| **Media, Newspaper/TV ad** |  | **FMNCH information leaflet** |  |
| **Other (please state)** |  |  |  |