

**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 sending a letter addressed to the Director of Care**  |

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| **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:       |

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| **Ethnic Group (mandatory)** |
| **White** | [ ]  English/Welsh/Scottish/Northern Irish/British [ ]  Irish[ ]  Any other White background (please specify)  | [ ]  Gypsy or Irish Traveller  |
| **Mixed Multiple Ethnic Groups** | [ ]  White and Black African[ ]  White and Asian[ ]  Any other mixed/multiple ethnic background (please specify)  | [ ]  White and Black Caribbean  |
| **Asian or Asian British** | [ ]  Indian[ ]  Bangladeshi[ ]  Any other Asian background (please specify) | [ ]  Pakistani[ ]  Chinese |
| **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 |

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| **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):       |
| Ehnic Group/Religion (if different to above):       | Ehnic Group/Religion (if different to above):       |

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| **Siblings** |
| Name: | Male/Female | DOB | Health Needs |
| 1.       |       |       |       |
| 2.       |       |       |       |
| 3.       |       |       |       |
| 4.       |       |       |        |
| 5.       |       |       |       |
| 6.       |       |       |       |

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| **Professional Involvement – Medical** |
| General Practitioner (GP):       |
| Practice address:       |
| Postcode:       |
| Telephone:       | Fax:       |
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| **Consultant 1:**      Hospital:       | Title/area of practice:       |
| Telephone:       |
| **Consultant 2:**      Hospital:       | Title/area of practice:       |
| Telephone:       |
| **Consultant 3:**      Hospital:       | Title/area of practice:       |
| Telephone:       |

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| **Professional Involvement – Others****e**.g. Health Visitor, School Nurse, Children’s Community Nurse, Social Worker, Pysiotherapist, Speech and Language Therapist |
| Name | Title/Role | Telephone |
| 1.
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| **Full medical background:**     Please continue on a separate sheet if necessary |

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| **Current medical treatment:**     Please continue on a separate sheet if necessary |

**Mandatory – please fill in all sections on this page**

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| **Current family situation additional and supporting information** |
| What help is the family looking for from Forget Me Not Children’s Hospice?       |
| Have the child’s parents (or those with parental responsibility) consented to the referral? Yes [ ]  No [ ]  |
| In order to process the referral, we will need to contact the professionals involved in caring for the child. This is normally the child’s GP and consultant paediatrician. |
| Can we contact your child’s GP, consultant and other professionals for more medical information? Yes [ ]  No [ ]  |
| Who would be the appropriate consultant to approach?       |
| Is the child subject to any Safeguarding plans? Yes [ ]  No [ ]  |
| Any additional information?       |

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| **To help Forget Me Not make an informed decision are there any known risks within the family’s home 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.** |

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| **Referrer** |
| Name:       | Relationship to child/job title:       |
| Telephone Number:       | Mobile Number:       |
| Email Address:       |  |
| Signature:       | Date:       |

**Please return this form by post to: The Director of Care, Forget Me Not Children’s Hospice, Russell House, Fell Greave Road, Huddersfield, HD2 1NH or email it to:** **care@forgetmenotchild.co.uk**

**Tel: 01484 411042**

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

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