

**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 |
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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**](mailto: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) |  |