Care Referral Form

Referral type: routine ☐ urgent ☐ symptom control ☐ end of life ☐

Child's details

Surname:
First name(s):
Date of Birth: Gender: Male ☐ Female ☐
NHS Number:
Home address:

Post Code:
Telephone numbers:

Email:
Religion:
Ethnic Group:
First Language:
Nursery, school or college attended:
CCG:

Diagnosis:

Diagnostic key:

Carer's details

Carer 1: Parental Responsibility ☐	**Carer 2:** Parental Responsibility ☐
Name:	Name:
Relationship to child:	Relationship to child:
First language:	First language:
Interpreter required: Yes ☐ No ☐	Interpreter required: Yes ☐ No ☐
Address (if different to above):	Address (if different to above):
Ethnic group:	Ethnic group:
Health Needs:	Health Needs:

Siblings

Name	Male/Female	DoB	Health needs
1			
2			
3			
4			
5			
6			

Professional involvement – medical

General Practitioner (GP):

Practice address

Post Code:

Telephone:

Consultant 1		**Consultant 2**	
Hospital address		Hospital address	
Telephone:		Telephone:	
Consultant 3		**Consultant 4**	
Hospital address		Hospital address	
Telephone:		Telephone:	

Professional involvement – allied professionals

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		
9		
10		

Nursing, social and medical history

Please continue on a separate sheet if necessary

Current treatment

Please continue on a separate sheet if necessary

Child's understanding of their diagnosis and prognosis

Details of regular family support

Other short breaks or community support

Consent

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

Yes ☐ No ☐

Has the young person consented to the referral? (if applicable)

Yes ☐ No ☐

Referrer

Name

Relationship to child/job title:

Contact number:

Email address:

Date:

Referral taken by: Signed:

FOR OFFICE USE ONLY				
	Form received:	Family contacted:	Consent:	Signature:
	Letter to GP:	Letter to consultant:	On Computer:	Signature:
	Accepted/Not Accepted:	Died before admission:	On Computer:	Signature:
	Do not wish to use us at present:	Signature:	Now wish to use us:	Signature:
	Review date: NA ☐	Review date: NA ☐	Review date: NA ☐	Review date: NA ☐
	Re-referred:	Accepted/Not Accepted	On Computer:	Signature:
	Date of Death:	Place of Death:	On Computer:	Signature:
	No longer involved:		On Computer:	Signature:

This form must be completed and returned to Caroline Davies, Referral Team at Claire House Children's Hospice, Clatterbridge Road, Bebington, CH63 4JD