**Referral type. Please indicate:**

Urgent Non urgent End of Life Bereaved

**Child’s details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Surname: |  | Forename(s): |  | Known as: |  |
| Date of birth: |  | or expected date of delivery if not born yet: |  | NHS number: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Gender | Male: | [ ]  |  | Home Address: |  |
| Female: | [ ]  |  |
| Transgender: | [ ]  |  |
| Not known: | [ ]  |  | Postcode: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Religion/ beliefs: |  |  | Telephone numbers: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| First language(s) and or preferred method of communication: |  | Interpreter required: | Yes [ ]  No [ ]  |
|  |

**Consent:**

|  |
| --- |
| Please confirm that the child’s parents (or those with parental responsibility) have consented to the referral? Yes [ ]  Please confirm that the young person has consented to the referral? *(if applicable)* Yes [ ]  N/A [ ] Is parental responsibility held by or shared with a Local Authority? Yes [ ]  No [ ] Does the CYP / family agree to share their electronic care record? Yes [ ]  No [ ]  |

**Current family details:**

|  |  |  |
| --- | --- | --- |
| Parent / Carer |  | Parent / Carer  |
| Name: |  | Same address? | Yes | [ ]  |  | Name: |  | Same address? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| Address if different: |  |  | Address if different: |  |
| Telephone: |  | Email: |  |  | Telephone: |  | Email: |  |
| Gender | Male: |  | Relationship to child: |  |  | Gender | Male: |  | Relationship to child: |  |
| Female: |  | Do they have a disability? |  |  | Female: |  | Do they have a disability? |  |
| Transgender: |  | Ethnic group: |  |  | Transgender: |  | Ethnic group: |  |
| Not known: |  | Religion/ beliefs: |  |  | Not known: |  | Religion/beliefs: |  |
| Main language(s): |  |  | Main language(s): |  |
| Interpreter required? | Yes | [ ]  |  | Interpreter required? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| Do they read English? | Yes | [ ]  |  | Do they read English? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| If not, how do they communicate? |  |  | If not, how do they communicate? |  |
| Do they have parental responsibility? | Yes | [ ]  |  | Do they have parental responsibility? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| If no, who has parental responsibility? |  |  | If no, who has parental responsibility? |  |
| What are their contact details? |  |  | What are their contact details? |  |

**Diagnosis:**

|  |  |
| --- | --- |
| What is (or was) the diagnosis/diagnoses? |  |
| Date of diagnosis/diagnoses: |  |
| Infection Status: |
| MRSA Status: |  | C. Diff Status |  | Other Infection: |  |

|  |  |
| --- | --- |
| Please include further information you feel may be helpful in our decision making e.g. clinic letters, copy of Advance Care Plan (ACP) etc. |  |

|  |
| --- |
| Likely prognosis: |
|  |
| CYP understanding of their diagnosis and prognosis:  |
|  |

|  |
| --- |
| Current phase of illness – please check one box below |
|  [ ]  Stable [ ]  Unstable [ ]  Deteriorating [ ]  Dying [ ]  Unknown[ ]  Deceased  |

|  |
| --- |
| Has a Continuing Care Assessment been completed in the last year? Yes [ ]  No [ ]    |
| Have any advance care planning discussions taken place? If yes, please attach / include documentation. Is there a resuscitation/ReSPECT plan in place? Yes [ ]  No [ ]   |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are there any safeguarding concerns with the referred child and / or other members of the household? | Yes | [ ]  |  | If yes please give brief outline |  |
| No | [ ]  |

**Siblings (and other household family members)**

| Relationship to child (e.g. full, half step): | Sibling name: | Gender: | DOB: | DOD: | Do they have the same condition (Y/N) | Please specify if language ethnicity or religion are different? |
| --- | --- | --- | --- | --- | --- | --- |
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**Additional information such as any relevant current family circumstances**

|  |
| --- |
|  |

**Professionals involved with the child/young person**

**General Practitioner**

|  |  |  |  |
| --- | --- | --- | --- |
| GP Name: |  | Telephone: |  |
| Address: |  | Postcode: |  |
| Clinical Commissioning Group (CCG): |  | Email: |  |

**Consultants** *please complete for all consultants involved with child/young person*

| Name | Hospital / Medical Community | Speciality | Telephone number | Email |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
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**Other allied professionals involved** *please complete for health, education or social care e.g. Social Worker, Psychologist, Health Visitor, Community Children’s Nurse, Teacher, Occupational Therapist, Speech and Language Therapist, Physiotherapist*

| Name and Title: | Address: | Telephone number: | Email: | Type and frequency of support and service provided: |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
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**Please identify any other health and social care providers you are aware of that already give support to the family**

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Who or what prompted you to make this referral to EACH?  |  |

**Referrer**

By completing this referral form you are confirming that the family has agreed to the referral and has been given the ‘Introductory information about EACH’ leaflet.

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Job title:(if relevant) |  |
| Role: |  | Organisation: |  |
| Telephone numbers: |  | Email: |  |
| Signature: |  | Date: |  |

**Please return this completed form to** each.referrals@nhs.net