Keech Hospice Care
Children's Services

Referral Form

Type of referral	Urgent ☐	Routine ☐

Please contact Keech Hospice Care immediately on 01582 497871 if you have ticked the urgent referral box above.

Please complete this form in **BLOCK CAPITALS** and return to the address stated together with up-to-date clinic letters and any other relevant information.

Child's details

Surname:	Forename(s):	
Known as:	Date of birth:	
Gender: Male ☐ Female ☐	NHS number:	
Ethnic group:	Religion:	
Main language(s):	Interpreter required? Yes ☐ No ☐	
Home Address:		
Postcode:	Home telephone number:	
Email:		
Additional telephone numbers:	School/Nursery:	
Is the child subject to a Child Protection Plan?	Yes	No

Primary Diagnosis

Date of diagnosis: ___/___/___

Date of recognition of life-limited/life-threatening condition: ___/___/___

Does the child have an advanced care plan?	Yes	No
Has resuscitation been discussed with the child/family?	Yes	No

Keech hospice care

What was the outcome?

Parental consent for referral obtained?	Yes	No

Parental consent given to gain and share information with other professionals?	Yes	No

Family details

Mother/Carer

Name: D.O.B: ___/___/___

Address:

Postcode:

Gender: Male ☐ Female ☐ Main Language(s):

Interpreter required: Yes ☐ No ☐ Do they read English? Yes ☐ No ☐

Ethnic group: Religion:

Relationship to child:

Father/Carer

Name: D.O.B: ___/___/___

Address:

Postcode:

Gender: Male ☐ Female ☐ Main Language(s):

Interpreter required: Yes ☐ No ☐ Do they read English? Yes ☐ No ☐

Ethnic group: Religion:

Relationship to child:

Siblings

Sibling's name:	D.O.B:___/___/___	Gender:
Sibling's name:	D.O.B:___/___/___	Gender:
Sibling's name:	D.O.B:___/___/___	Gender:
Sibling's name:	D.O.B:___/___/___	Gender:
Sibling's name:	D.O.B:___/___/___	Gender:

Professionals' details

	Name	Address	Tel. No.	Email
GP				
Consultant 1				
Consultant 2				
Social worker				
Health visitor				
Community nurse				
Physiotherapist				
OT				
Local hospital				

Relevant medical history

Relevant social history

Any other/further information?

Reason for referral (For example, end of life care, symptom management, emotional/psychological support, in-patient stays).

Referrer's details

Name:
Address:
Postcode:
Email:
Relationship to child:
Date of referral:

OFFICIAL USE ONLY:

Date received:

Please return this form to:

Email: keech.childreferral@nhs.net

Keech Community Team, Keech Hospice Care, Great Bramingham Lane, Streatley, Luton LU3 3NT

Please call CIPU on 01582 497871 to check the referral has been received.

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