**Keech Hospice Care Referral Form**

**Children’s Services**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 |

**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 FemaleInterpreter 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 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**

GP

Consultant 1

Consultant 2

Social worker

Health visitor

Community nurse

Physiotherapist

OT

Local hospital

Name

Address

Tel. No.

Email

**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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