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| Newham Children’s Community Nursing Service – Referral Form |

Which Service do you require? Children’s Community Nursing Team Epilepsy Nursing

(Please tick)

Diana Palliative Care Continuing Care Nursing

(Nursing, Psychology and Play Specialist)

**Section A: Details of child**

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| --- | --- | --- | --- |
| Surname: | Date of birth: | | **Male / FEMALE** |
| Forenames: | Also known as: | | NHS No.  RiO No. |
| Address: | | | Post code: |
| Ethnicity:  Religion:  Language: | Parent/Carer name:  Relationship to child:  Telephone/Mobile: | | Parent/Carer name:  Relationship to child:  Telephone/Mobile: |
| Interpreter Required:  Language: | Weight: | | Alerts/Allergies: |
| Paediatric Consultant: | Base: | | Hosp No. |
| GP: | Address: | | GP Tel No. |
| School/Nursery: | School Nurse/Health Visitor: | | Tel No: |
| Child Safeguarding issues? **CIN / CP Plan / None**  *(circle)* | | Social Worker Contact: | |
| Have you discussed referral with parents? **Yes / No**  *(circle)* | | Do they agree to referral? **Yes / No**  *(circle)* | |

**Section B: Reason for referral**

|  |  |  |  |
| --- | --- | --- | --- |
| Diagnosis: | | | |
| Reason for referral (including previous medical history and details of equipment needed):    Discharge letter/ other report attached **Yes / No**  *(circle)* | | | |
| For hospital referrals: Date of hospital admission/attendance: | | Planned date of discharge: | |
| **Discharge planning meeting** date:  ***CCNS Must have at least 48hr notice of DPM to attend and may require 24- 48 hours’ notice to visit family at home for acute patients.*** | | | |
| **IF REFERRAL IS FOR WOUND PLEASE COMPLETE BELOW SECTION, WOUND REFERRALS WILL BE SEEN IN OUR DRESSING CLINIC. WE WILL CONTACT FAMILY/CARERS WITH DETAILS. *IF NOT PLEASE CONTINUE TO SECTION C*** | | | |
| Last wound review: | Last Dressing Change: | | Dressings supplied: Yes No *(circle)* |

**Section C: Services involved**

|  |  |  |  |
| --- | --- | --- | --- |
| Please tick, to your knowledge of other services involved | | Dietetics | Speech & Language |
| Child Development Service | Physiotherapy | Occupational Therapy | Wheelchair Services |
| CFCS/CAMHS | Social Services | Voluntary Sector / Other | PSHVT |
| Richard House | Tertiary Consultant Name & Hospital: | | |
| Have Clinical Psychology services been offered to family already from outside the Diana Team? **Yes / No** *(circle)* | | | |

**Section D: Details of person making referral**

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| --- | --- |
| Name: | Job Title: |
| Base: | Telephone Number: |
| Email: | Fax Number: |
| Referral Date | Signed: |

**Section E:** **OUR OFFICE USE ONLY**

|  |  |  |
| --- | --- | --- |
| Date referral received: | Team: | Triaged by: |
| Initial contact date/time: | Contact with: | Named Nurse: |
| Associate Nurse: | Planned date for visit: | Long Term Short Term *(circle)* |
| Priority |  |  |

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