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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**

|  |  |  |
| --- | --- | --- |
| Surname:  | Date of birth:  | **Male / FEMALE** |
| Forenames:  | Also known as:  | NHS No. RiO No.  |
| Address:  | **Please circle relevant Post code**: E6, E7, E12, E13, E15, E16,E20 |
| Ethnicity: Religion:Language:  | Parent/Carer name:Relationship to child:Telephone/Mobile:  | Parent/Carer name:Relationship to child:Telephone/Mobile:  |
| Interpreter Required: Y/NLanguage:  | Weight:  | Alerts/Allergies:  |
| Paediatric Consultant: | Base:  | Hosp No.  |
| Newham GP: **Contact CCG about Cross charging, if not Newham** | 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**

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| **Diagnosis:**  |
| **Reason for referral (including previous medical history and details of equipment needed):** **Please attach discharge letter/ other report attached**  |
| **Request date of first home visit:** | **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*** |

**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**

|  |  |
| --- | --- |
| 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  |  |  |

**Professionals and Colleagues:**

If you have positive feedback for someone in Specialist Children and Young People's Service (SCYPS), we would love for you to submit a **#GREATIX!**Direct feedback will be given to the individual and shared across SCYPS.

Click below to send a #GREATIX

<https://forms.office.com/Pages/ResponsePage.aspx?id=slTDN7CF9UeyIge0jXdO46LkmfCPllRGqmyCih9I4WpUQktOU1dIVjJaT05QWkhQTEJZWUI0M0dIWS4u>