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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: | | | **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/N  Language: | 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**

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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 |  |  |

**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>