

Children’s Continuing Care Referral and Screening Form

Name

D.O.B NHS no. Gender

 Home Address

Contact Numbers

Professional completing

screening tool

*Name and role*

Parental responsibility

*Name, relationship*

*and address (if*

*different from above)*

Parties present

at screening

GP and Practice

Health Visitor/

School Nurse

*Name and*

*base*

Other Professionals

Involved

*Name, role,*

*contact details*

Reason for referral *(include a summary of health needs and what support the referrer feels is needed)*

Please indicate yes or no in response to the following questions providing evidence supporting your answer in the space provided.

|  |  |
| --- | --- |
| CARE DOMAIN | QUESTION |
| 1. Breathing
 | Does the child require any of the following?* Tracheostomy care
* Ventilation
* Secretion Management (please specify if oral/naso-pharyngeal/oro-pharyngeal suction)
* Respiratory Physiotherapy
* Oxygen

Yes / No |
| Supporting Information |
| 1. Eating and Drinking
 | Does the child require assistance with nutritional intake that is not appropriate to their age? Yes / No |
| Supporting Information |
| 1. Mobility
 | Is the child able to assist in mobilizing independently?Do they require support from one or more people?Yes / No |
| Supporting Information |
| 1. Continence and elimination
 | Does the child require assistance with elimination that is not appropriate to their age? Yes / No |
| Supporting Information |
| 1. Skin and Tissue Viability
 | Is the child at high risk of skin breakdown?Does the child have any tissue viability issues, open wounds or an active skin condition?Yes / No |
| Supporting Information |
| 1. Communication
 | Is the child able to communicate their basic wants or needs?Yes / No |
| Supporting Information |
| 1. Drug therapies and medicines
 | Does the child need medication daily that requires a trained person to administer or manage this? Yes / No |
| Supporting Information |
| 1. Psychological and emotional needs
 | Does the child have significant psychological or emotional needs?Does the child suffer from a mental health condition that requires specialist intervention? Yes / No |
| Supporting Information |
| 1. Seizures
 | Does the child suffer from:* Seizures requiring regular rescue medication?
* Severe uncontrolled seizures requiring hospital admission?
* Overnight tonic/clonic seizures?

Yes / No |
| Supporting Information |
| 1. Challenging behaviour
 | Does the child’s behaviour pose a significant risk to themselves or others? Yes / No |
| Supporting Information |

This information is now to be forwarded to the Continuing Care Nurse Specialist in the Community Children’s Nursing Service.

Please obtain consent from the child’s legal guardian to share the information obtained.

The above information will be used to decide whether your child is eligible for a continuing care assessment.

Name Relationship

 to child

Signature Date

Name Relationship

 to child

Signature Date

Screening tool completed by:

Name Role

Signature Date

Please email to: elft.scypscontinuingcarenewham@nhs.net

Continuing Care Nurse Specialist Team

Appleby Health Centre,

63 Appleby Road,

London,

E16 1LQ

**Tel:** 0203 738 7063

**Website:** [www.elft.nhs.uk](http://www.elft.nhs.uk)

**Email:** elft.scypscontinuingcarenewham@nhs.net

**For use by Continuing Care Nurse Specialist**

|  |
| --- |
| **Eligible for continuing care assessment.** |
| Rationale for decision: |
| Assessment appointment made*(date, time, venue)* |  |
| Joint assessment required?*(professionals confirmed to attend)* |  |

|  |
| --- |
| **Not eligible for continuing care assessment.** |
| Rationale for decision: |
| Results relayed to referrer?*(date, time)* |  |
| Results relayed to parent?*(date, time)* |  |