 

**Community Children’s Nursing Team Referral Form**

**Anything marked with \* MUST be filled in. Thank you**

Please telephone 🕿 **01302 379528** to discuss this referral prior to faxing. Please note 24hours notice is required for all visits.

Please complete form as fully as possible. Please **fax** completed form to 🖷 **01302 379524**.

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| \* Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* Male: 🞏 Female: 🞏Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ethnic group:\* Discharge address if different from above: | \* NHS No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* Home Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* Mobile Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Main Carer’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Parental Responsibility:Other Significant Family members:Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* Spoken Language: |
| \* Consultant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* H/V or School Nurse:  | \* Social Worker (current or previous):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* Child Protection Plan: 🞏CIN: 🞏 EHAF: 🞏 CAF: 🞏 TAC: 🞏  |
| \* Reason for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Expected date of discharge:\*First visit required on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \* Diagnosis / relevant medical history:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Current weight:Date:(must be recorded if requesting IVABs) |
| \* Risk assessment: (To be completed in all cases) Think –What would you like to know if visiting this family alone? Please state any concerns regarding family which might impact on staff safety: drug abuse, violence, domestic abuse etc |

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| Patient name:  Date of Birth:  | NHS Number: |

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| Infection control Status: | Any other Health professionals involved:Name:Contact Details |
| Last 2 PEWS score:Comments any clinical information: | Name:Contact Details: |

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| \* Current medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \*Equipment required (please provide at least 7days supply) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*If child/young person is on IV antibiotics then medication and supplies for the duration of the course should be provided.* |
| \* Referred by: (print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* Organisation / Ward: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \*Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**For IV Administration Only – All of the details must be completed** History of how the medication has been given in hospital

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| Name of Drug: | Dose: |
| Start Date: | End Date: |
| Infusion: Yes 🞏 No 🞏 | Rate: (even if blous) |
| Dilution Type:Amount: | Made up to: mls |
| Access Type:Date inserted:PICC/Hickman line measurement from tip to insertion point:If peripheral and medication required for more than 72 hours please detail plan for change: | Type of FlushAmount of FlushComments: |
| Date of last dressing and bung change: |  |
| Review Date: | Last 2 VIP scores: 1, 2,  |

**All medications need to be prescribed on our community prescription chart.**

**To be completed by CCN team**

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| --- | --- | --- | --- | --- |
| Date received: | Named Nurse: | Accepted:Yes: 🞏No: 🞏 | Date of First visit: | Date on TPP |

**Community Children’s Nursing Team Tel 🕿 : 01302 379528**

Cantley Health Centre, Middleham Rd, **Fax 🖷 : 01302 379524**

Doncaster, DN4 6ED.