 [](http://nww.intranet.rdash.nhs.uk/)

**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 Flush  Amount of Flush  Comments: |
| 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.