Care Referral Form

Martin House Children's Hospice

Referral type: routine ☐ urgent ☐ symptom control ☐ end of life ☐ community ☐

Child's details

Surname:

First name(s):

Date of Birth: Gender: Male ☐ Female ☐

NHS Number:

Home address:

Postcode:

Telephone numbers:

Email:

Religion:

Ethnic group:

First language:

Nursery, school or college attended:

CCG:

Diagnosis:

Diagnostic key:

Carer's details

Carer 1: Parental responsibility? (please tick) ☐	**Carer 2:** Parental responsibility? (please tick) ☐
Name:	Name:
Relationship to child:	Relationship to child:
First language:	First language:
Interpreter required: Yes ☐ No ☐	Interpreter required: Yes ☐ No ☐
Address *(if different to above)*:	Address *(if different to above)*:
Ethnic group:	Ethnic group:
Health needs:	Health needs:

Siblings

	Name	Male/Female	DoB	Health needs
1				
2				
3				
4				
5				
6				

Professional involvement - medical

General Practitioner (GP):

Practice address:

Postcode:

Telephone:

Consultant 1:		**Consultant 1**:	
Hospital address:		Hospital address:	
Telephone:		Telephone:	
Consultant 2:		**Consultant 2**:	
Hospital address:		Hospital address:	
Telephone:		Telephone:	

Professional involvement – allied professionals

E.g. Health Visitor, School Nurse, Children's Community Nurse, Social Worker, Physiotherapist, Speech and Language Therapist…

	Name	Title/Role	Telephone
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Nursing, social and medical history

Please continue on a separate sheet if necessary

Current treatment

Please continue on a separate sheet if necessary

Child's understanding of their diagnosis and prognosis

Details of regular family support

Other short breaks or community support

Consent

Have the child's parents (or those with parental responsibility) consented to the referral? yes ☐ no ☐

Has the young person consented to the referral? *(if applicable)* yes ☐ no ☐

Referrer

Name: _____

Relationship to child/job title: _____

Contact number: _____

Email address _____

Date: _____

Referral taken by: Signed:

for office use only				
	Form received:	Family contacted:	Consent:	Signature:
	Letter to GP:	Letter to Consultant:	On Computer:	Signature:
	Accepted/Not Accepted	Died before admission:	On Computer:	Signature:
	Do not wish to use us at present:	Signature:	Now wish to use us:	Signature:
	Review date: NA ☐	Review date: NA ☐	Review date: NA ☐	Review date: NA ☐
	Re-referred:	Accepted/Not Accepted	On Computer:	Signature:
	Date of death:	Place of death:	On Computer:	Signature:
	No longer involved:		On Computer:	Signature: