Care Referral Form

CONFIDENTIAL once completed

Martin House Children's Hospice

Here when families need us most

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:			
Mobile:			
Email:			
Religion:			
Ethnic group:			
First language:			
Nursery, school or college attended:			
CCG:			

Is the child known to another hospice? No ☐ Yes ☐ *If yes, please state which hospice*

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:	Interpreter required:
Address (*if different to above*):	Address (*if different to above*):
Ethnic group:	Ethnic group:
Health needs:	Health needs:

Brothers and sisters

Name	M/F	DoB	Heath needs
1			
2			
3			
4			
5			

Professional involvement (medical)

General Practitioner (GP):			
Practice address:			
		Postcode:	
Telephone:			
Consultant 1:		**Consultant 2:**	
Hospital address:		Hospital address:	
Telephone:		Telephone:	
Consultant 3:		**Consultant 4:**	
Hospital address:		Hospital address:	
Telephone:		Telephone:	

Are there any safeguarding concerns around the child or family?

Professional involvement (allied professionals)

Eg: Health Visitor, School Nurse, Children's Community Nurse, Social Worker, Physiotherapist, Speech and Language Therapist, etc.

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

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

Please note: If you do not complete the below, we will be unable to progress with this referral.

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 ☐

By ticking this box you are giving consent for us to share information with and from your other clinicians on SystmOne ☐

Martin House uses a clinical computer system, SystmOne, which lets health staff record patient information securely, onto a computer. This information can be shared with other clinicians so that everyone caring for a patient is fully informed about things like their medical history, allergies and medications.

- **Sharing out:** This controls whether information we enter can be seen by the rest of you/your health team. An example of this is that your GP will be able to see straight away if we make any medication changes.
- **Sharing in:** This controls whether we are able to access information which is sharable at other healthcare services. As an example, we may be able to see your last clinic letter or details of any medication changes made elsewhere. We may also be able to see when you are in hospital which is helpful and may enable us to offer support.

Referrer

Name:
Relationship to child/job title:
Contact number:
Email address:
Date:

For professionals only: please complete the additional referral criteria form

Please return the completed form by email to **care@martinhouse.org.uk** or by post to:
Care Referral Team Panel, Martin House Children's Hospice, Grove Road, Boston Spa, Wetherby, LS23 6TX

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 at present:	Signature:	Now wish to use us:	Signature:
Review date: N/A ☐	Review date: N/A ☐	Review date: N/A ☐	Review date: N/A ☐
Re-referred:	Accepted/Not Accepted:	On Computer:	Signature:
Date of death:	Place of death:	On Computer:	Signature:
No longer involved:		On Computer:	Signature: