**Little Havens referral form – Children and Young People aged 0-25 years**

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| **Patient Name:** | **D.O.B.** | **Gender:**  | **NHS No:** |
| **Diagnosis (& date if known):** | **Main Language:****Interpreter needed:**Yes/No | **Religion & Spiritual support:** |
| **Current Condition**: [ ]  Stable [ ]  Unstable [ ]  Deteriorating [ ]  Dying |
| **Has the family / patient consented to referral?** Yes No**Verbal consent to access Medical Record?** Yes No | **Date of referral:** |
| **Referrer details:**Name:Relationship to Child/Young Person:Tel No:Email: | **Reason for referral:**Name and signature of person taking referral |
| **Parent / Carer / Next of Kin:** (delete as appropriate)Parental Responsibility: Y / NRelationship:  | **Parent / Carer / Other contact name:** Parental Responsibility: Y / NRelationship: |
| **Patient Address:****Postcode:****Telephone Number:**Home: Mobile:Email:Access to home issues: Key Safe? Y / N | **Parental Address if different:****Postcode****Telephone Number:**Home:Mobile:Email: |
| **SIBLINGS:**Name: DOB: | Name: DOB: | Name:DOB: |
| **Family & Social History:** |
| **Social Worker:** | **Child Protection/safeguarding concerns/Lone Worker Risk?**  Yes No |
| **Medical History:** |
| Seizures: |
| Medication: |
| Breathing: |
| Mobility: |
| Nutrition: |
| Pain: |
| Behaviour: |
| Other / equipment: |
| **Professionals Involved** | **Address & Telephone Number** |
| GP Name: |  |
| Consultant: | Hospital: |
| Community Nurse: |  |
| Health Visitor / School Nurse: |  |
| Occupational therapist: |  |
| Physiotherapist: |  |
| Dietician: |  |
| Community Pharmacist: |  |
| School (if applicable):Teacher: |  |
| Other: |  |
| **Advance Care Planning:** Does the patient have a Preferred Priorities for care document completed? Yes No | Does the patient have a verbal Preferred Priorities for care? Yes No |
| Is the patient on the End of Life Register (last 12 months) Yes No | Does the patient have an indefinite DNAR in place? Yes No |