**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 / N  Relationship:  Please detail any communication or accessibility needs: | | | **Parent / Carer / Other contact name:**  Parental Responsibility: Y / N  Relationship:  Please detail any communication or accessibility needs: | | | |
| **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 | | |