**Little Havens referral form – Children and Young People aged 0-18 years**

Child/young person’s details:

|  |  |  |  |
| --- | --- | --- | --- |
| Full name: |  | Known as: |  |
| Date of birth: |  | NHS number: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Gender | Male: | [ ]  | Gender Identity | Male: | [ ]  |
| Female: | [ ]  | Female: | [ ]  |
| Choose not to disclose: | [ ]  | Non-binary: | [ ]  |
| Transgender: | [ ]  |
| Other: |  |
| Religion/ beliefs: |  | Preferred Pronouns: |  |

|  |  |
| --- | --- |
| Home Address: |  |
|  |
|  |
| Postcode: |  |
| Telephone numbers: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| First language(s) and or preferred method of communication: |  | Interpreter required: | Yes [ ]  No [ ]  |
|  |

Consent:

|  |
| --- |
| Please confirm that the child’s parents (or those with parental responsibility) have consented to the referral? Yes [ ]  Please confirm that the young person has consented to the referral? *(if applicable)* Yes [ ]  No [ ]  N/A [ ] Is parental responsibility held by or shared with a Local Authority? Yes [ ]  No [ ] Does the child/young person / family agree to share their health electronic care record? (*This help Little Havens to review the most up to date clinical information about the child or young person*)  Yes [ ]  No [ ] If accepted for care by Havens Hospices, do you consent to be added to EPaCCS (Electronic Palliative Care Coordination System)? Yes [ ]  No [ ]  |

Referrer’s details

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Email: |  |
| Relationship to child/young person: |  | Date of referral: |  |
| **Please complete the following sections if you are not the child’s parent/carer/guardian:** |
| Job title |  | Organisation: |  |
| Telephone numbers: |  | Email: |  |

Current family details:

|  |  |  |
| --- | --- | --- |
| Parent / Carer |  | Parent / Carer  |
| Name: |  | Same address? | Yes | [ ]  |  | Name: |  | Same address? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| Address if different: |  |  | Address if different: |  |
| Telephone: |  |  | Telephone: |  |
| Email: |  |  | Email: |  |
| Gender Identity | Male: |  | Female: |  |  | Gender Identity | Male: |  | Female: |  |
| Non-binary: |  | Other: |  | Non-binary: |  | Other: |
| Preferred Pronouns: |  |  | Preferred Pronouns: |  |
| Relationship to child: |  |  | Relationship to child: |  |
| Do they have a disability? |  |  | Do they have a disability? |  |
| Ethnic group: |  |  | Ethnic group: |  |
| Main language(s): |  |  | Main language(s): |  |
| Interpreter required? | Yes | [ ]  |  | Interpreter required? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| Do they read English? | Yes | [ ]  |  | Do they read English? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| If not, how do they communicate? |  |  | If not, how do they communicate? |  |
| Do they have parental responsibility? | Yes | [ ]  |  | Do they have parental responsibility? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| If no, who has parental responsibility? |  |  | If no, who has parental responsibility? |  |
| What are their contact details? |  |  | What are their contact details? |  |

Diagnosis:

|  |  |
| --- | --- |
| Please tell us about the child/young person’s medical condition(s), health, and nursing needs: |  |
| If applicable - date of diagnosis: |  |

|  |  |
| --- | --- |
| Who or what prompted you to make this referral to Little Havens?  |  |

|  |
| --- |
| Is the child/young person likely to live into adulthood? : |
|  |
| What is the child/young person’s understanding of their diagnosis and prognosis:  |
|  |

|  |
| --- |
| Current phase of illness – please check one box below |
|  [ ]  Stable [ ]  Unstable [ ]  Deteriorating [ ]  Dying [ ]  Unknown[ ]  Deceased**Please telephone us if you require an urgent response (01702 552 200)**   |

|  |
| --- |
| Have any advance care planning discussions taken place? If yes, please attach / include documentation. Is there a resuscitation/ReSPECT plan in place? Yes [ ]  No [ ]   |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are there any safeguarding concerns with the referred child and / or other members of the household? | Yes | [ ]  |  | If yes, please give brief outline |  |
| No | [ ]  |

Siblings (and other household family members):

| Relationship to child (e.g. full, half step): | Sibling name: | Gender Identity: | DOB: | DOD: | Do they have the same condition (Y/N) | Please specify if language ethnicity or religion are different? |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Additional information such as any relevant current family circumstances:

|  |
| --- |
|  |

Professionals involved with the child/young person

**General Practitioner**

|  |  |  |  |
| --- | --- | --- | --- |
| GP Name: |  | Telephone: |  |
| Address: |  | Postcode: |  |

**Medical Consultants** *please complete for all consultants involved with child/young person*

| Name | Hospital / Medical Community | Speciality | Telephone number | Email |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Other allied professionals involved** *please complete for health, education or social care e.g. Social Worker, Psychologist, Health Visitor, Community Children’s Nurse, Teacher, Occupational Therapist, Speech and Language Therapist, Physiotherapist*

| Name and Title: | Address: | Telephone number: | Email: | Type and frequency of support and service provided: |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Please return this completed form via our website here** [**www.havenshospices.org.uk/refer/refer-a-child-to-little-havens/**](http://www.havenshospices.org.uk/refer/refer-a-child-to-little-havens/)