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

Child/young person’s details:

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

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

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

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

Consent:

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| 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

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| --- | --- | --- | --- | --- | --- | --- |
| 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:

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

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

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

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| --- |
| 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)** |

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

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| 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? |
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Additional information such as any relevant current family circumstances:

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Professionals involved with the child/young person

**General Practitioner**

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| --- | --- | --- | --- |
| 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 |
| --- | --- | --- | --- | --- |
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**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: |
| --- | --- | --- | --- | --- |
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**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/)