



## ASSESSMENT OF REFERRAL

Date visited	Weight	Size
Social, Medical or Nursing problems		
How is the child fed		
Breathing (any difficulties)		
Seizures      YES / NO		
How frequent	How are they controlled	
Medication		

Ref No \_\_\_\_\_

How often does the child visit hospital (Reasons for admission)

Parents awareness of condition

Parents awareness of prognosis

Childs awareness of condition

Plans for future care/resuscitation

Religious/Spiritual /Cultural needs

**To which of the following groups do you consider you belong? (please tick one box)**

<b>WHITE</b>	<b>BLACK OR BLACK BRITISH</b>	<b>ASIAN OR ASIAN BRITISH</b>	<b>CHINESE OR OTHER ETHNIC GROUP</b>
British <input type="checkbox"/>	Caribbean <input type="checkbox"/>	Indian <input type="checkbox"/>	Chinese <input type="checkbox"/>
Irish <input type="checkbox"/>	African <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Other ethnic background (please write below) <input type="checkbox"/>
Other white background (please write below) <input type="checkbox"/> .....	Other black background (please write below) <input type="checkbox"/> .....	Bangladeshi <input type="checkbox"/>	.....
		Other Asian background (please write below) <input type="checkbox"/> .....	

