

Child's Name		dob	Sex (M/F)	Code	ACT code	Ref No
Section above to be completed by hospice staff only						
Diagnosis						
Address			Permanent change of address (<i>hospice use only</i>)			
Postcode			Postcode			
Telephone No			Telephone No			
Father first name		Surname		Mother first name		Surname
How do you wish to be addressed when we send you post and verbally Mailings		Verbally		Parental responsibility		
Hospital & Ward if in Hospital			School			
Name & dob (sibling)		Name & dob (sibling)		Name & dob (sibling)		
Name & dob (sibling)		Name & dob (sibling)		Name & dob (sibling)		
Name & Address of GP			Name & Address of Consultant			Home Health District
Name & Address of SW/HV or other professional involved			Names, relationship and Tel no of any regular family supporters			
Name, Address & relationship of person making referral				Signature of person taking the referral		
				To be signed by hospice staff only		
Tel No				Date of referral		

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)

WHITE	BLACK OR BLACK BRITISH	ASIAN OR ASIAN BRITISH	CHINESE OR OTHER ETHNIC GROUP
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"/>	

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Date consent forms sent		Date consent forms received		Date On Computer		
Date Letter to GP		Date Letter to Consultant		Other professionals		
Date of Panel		Members of Panel present				Signature
		Margaret HICKIE	Sr Maureen	Dr Emma	Home-care	OTHER
Date accepted	GP informed	Consult informed	Parent/Guard informed	Referrer informed	Signature	
Date not accepted	GP informed	Consult informed	Parent/Guard informed	Referrer informed	Signature	
Date of death		Place of death		On computer		
				Signature		