|  |  |
| --- | --- |
| NHS Number: | Child’s Name: |
| Ethnic Group: | DoB: | Ref: |
| GP Name: | Consultant Name(s): |
| Primary Medical Diagnose(s) |
| Medications |
| **Seizures**Does the Child suffer with Seizures? Yes No If Yes please provide details on types and frequency of seizures that the child suffers with. |

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| **Hospital Admissions**Has the child ever been admitted to HDU/ICU YES NOIf yes please give details:Has the child had any other significant/prolonged hospital stays? YES NOIf yes please give details:How many hospital admissions has the child had in the past 12 months?Is there any planned upcoming surgery? YES NOIf yes please give details: |
| **Prognosis**Do you expect the child to live beyond early twenties? YES NOLikely prognosis (and reason for answer)Parents/carers understanding of prognosis. Child/Young Persons understanding of prognosis. |
| Is there an Advanced Care Plan in place? |

**Vulnerability Factors**

Which of the below factors apply, these are particularly relevant to children and young people in the ACT 4 category – (neurological disability – eg Cerebral Palsy) but please answer for all referrals.

Children and young people likely to be accepted for Childrens Hospice services and to benefit most from specialist palliative care would have orange/red features in more than one category, although each child will be considered on an individual basis.

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| **Respiratory** | Please Tick  |
| Two plus chest infections requiring hospitalisation per year |  |
| Vulnerable airway |  |
| PICU admission for lower respiratory tract infection |  |
| Scoliosis impacting on respiratory function |  |
| Apnoea’s requiring intervention  |  |
| Requirement for long term oxygen therapy or NIV at home |  |
| Tracheostomy and/or 24-hour ventilation |  |

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| **Neurological** | Please Tick  |
| Epileptic activity needing medication |  |
| Poor seizure control despite numerous drugs |  |
| Frequent use of seizure rescue medication (daily basis) |  |
| Episodes of status epilepticus requiring intensive treatment  |  |

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| **Gastrointestinal**  | Please Tick  |
| Gastrostomy |  |
| Jejunostomy |  |
| Severe uncontrolled reflux despite maximal treatment |  |
| Pain/distress associated with feeding requiring progressive feeding reduction |  |
| Severe gut failure requiring TPN  |  |

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| **Other System Failure** | Please Tick  |
| Organ failure awaiting transplant |  |
| Unstable cardiac condition awaiting surgery  |  |

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| Any other relevant information |

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| Form completed by: |
| Signature:  |
| Date: |
| Email address: |
| Contact Number: |