Office Use Only Ref. No. \_\_\_\_\_\_\_\_\_\_\_\_

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| Email to Sharon Doodson, Director of Care sharon.doodson@francishouse.org.uk or post to Francis House Children’s Hospice, 390 Parrswood Road, Didsbury, Manchester, M20 5NA |

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| **ARE PARENTS AWARE OF THIS REFERRAL?** |
| **Yes** - proceed with referral **No** - seek parent’s consent before completing |
| **NB: Parents are required to sign the attached Parental Consent Forms and return with this referral** |

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| Name, address and relationship of person making referral |
| Tel No | Date of Referral |
| Email |
| Child or young person’s name | Address |
| Dob | Male/Female | Telephone no. |
| Diagnosis |
| Mother first name | Surname | DOB | Father first name | Surname | DOB |
| Address | Address |
| Telephone & Email | Telephone & Email |
| Parental responsibility |
| Name & dob (sibling) | Name & dob (sibling) | Name & dob (sibling) | Name & dob (sibling) | Name & dob (sibling) | Name & dob (sibling) |
|  |  |  |  |  |  |
| GP name, address, telephone, fax & email | Consultant(s) name, address, telephone, fax & email(Please state speciality e.g. neurology, respiratory, cardiologist)  |
| SW/HV or other professional involved name address, fax & email  |

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| Social, medical or nursing problems |
| How is the child/young person fed |
| Breathing (any difficulties) |
| Seizures | Yes | / | No |
| How frequent | How are they controlled |
| Medication  |
| Office Use Only Ref No. \_\_\_\_\_\_\_\_\_\_ |
| Hospital and ward (if in hospital) |
| How often does the child visit hospital (reasons for admission) |
| School details |
| Parents awareness of condition |
| Parents awareness of prognosis |
| Child/young person’s awareness of condition |
| Plans for future care / resuscitation |
| Religious / Spiritual / Cultural Needs |
| Any other comments |

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| **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 | 🞏 | Caribbean | 🞏 | Indian | 🞏 | Chinese | 🞏 |
| Irish | 🞏 | African | 🞏 | Pakistani | 🞏 | Other ethnic background(please write below)  | 🞏 |
| Other white background (please write below)  | 🞏 | Other black background(please write below)  | 🞏 | Bangladeshi | 🞏 |  |  |
|  |  |  |  | Other Asian background(please write below)  | 🞏 |  |  |

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| **Date consent letter received. Yes No** Medical information letters not to be sent without prior consent |
| **Requested Medical Information Forms** | **Referral Decision** Accepted DeclinedIf declined state reason above**Present at decision meeting** (please circle)Medical Co-ordinator Director of CareLead FH Lead FLHomecare |
| Consultant Name Dept Date letter sent |
| Consultant Name Dept Date letter sent  |
| Consultant Name Dept Date letter sent |
| Other professionals Name Date letter sent |
| **Date accepted** | Date Parent/Guardian informed Signature  | Date Referrer informedSignature |
| **Date declined**  | Date Parent/Guardian informed Signature   | Date Referrer informedSignature |

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