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

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| Email to Jasmine Leah [jasmine.leah@francishouse.org.uk](mailto:jasmine.leah@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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| Office Use Only Ref No. \_\_\_\_\_\_\_\_\_\_ | | | | |
| 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 Declined    If declined state reason above  **Present at decision meeting** (please circle)  Medical Co-ordinator Director of Care  Lead FH Lead FL  Homecare |
| 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 informed  Signature | |
| **Date declined** | Date Parent/Guardian informed  Signature | Date Referrer informed  Signature | |

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