rainbows
Brightening short lives

Long Term Ventilation & Step Down Services

Referral Form

Please download & save before completion

Child's Details

Name:	**Known As:**
Date of Birth:	**NHS Number:**
Gender:	**Religion:**
Home Address:	

Any safeguarding concerns with referred child or other members of household?

☐ **Yes** ☐ **No**

If yes, please give brief details including Social Worker name & contact details

Social Worker Name:	**Contact Number:**
Email Address:	

Is the child a looked after child?

☐ **Yes** ☐ **No**

Family Details - Parent/Carer 1

Name:		PR?	☐	Yes	☐ No
Home Address:					
Email:					
Phone Number:		Gender:			
Relationship to child:		Ethnicity:			
Do they have a disability?					
Main Language:					
Interpreter required?	☐ Yes ☐ No	Do they read english?	☐ Yes ☐ No		

Family Details - Parent/Carer 2

Name:		PR?	☐	Yes	☐ No
Home Address:					
Email:					
Phone Number:		Gender:			
Relationship to child:		Ethnicity:			
Do they have a disability?					
Main Language:					
Interpreter required?	☐ Yes ☐ No	Do they read english?	☐ Yes ☐ No		

Which parent or carer will be able to resident at Rainbows for Step Down?

☐ Parent/Carer 1 ☐ Parent/Carer 2

Has the child been assessed for continuing care funding?

☐ Yes ☐ No

Date Completed:	Outcome:

Carer Hours Planned:

Name of Care Agency:

Do they have suitable housing? ☐ Yes ☐ No

If not, who is leading on housing?

What stage of the housing process are the parents at?

Siblings and other household members

Relationship to child	Sibling Name	Gender	Date of Birth	Date of Death	Same Condition?	Language and Religion if different?

Any other relevant or key family circumstances or information?

Diagnosis and Medical Needs

Reason for Long Term Ventilation / Step Down referral?

Any other co-morbidities?

Nursing, social, medical needs and history? Include information on any other long term conditions requiring support during step down, for example catheter care?

Long Term Ventilation Needs

Level	Description	NIV / Tracheostomy	Y / N
High (Level 1)	Able to breathe unaided during day but needs to go onto a ventilator for supportive ventilation. Ventilation can be discontinued for up to 24 hours without clinical harm.		
Severe (Level 2)	Child requires ventilation at night for very poor respiratory function; has respiratory drive and would survive accidental disconnection, but would be unwell and may require hospital support.		
Priority (Level 3)	Child has no respiratory drive at all and is dependent on ventilation at all times. Child has no respiratory drive when asleep or unconscious who require ventilation and one-to-one support while asleep. Disconnection would be fatal.		

Ventilator:

Phillips Respironics Trilogy 100 ☐

Astral ResMed (min weight 5kg) ☐

Stella ResMed (min weight 13kg) ☐

Nippy Junior ☐

Settings at time of referral:

Interface?	Ventilator Settings – completed by referrer
Total Face Mask?	
Full Face Mask – type?	
Nasal Mask – type?	
Nasal Pillow – type?	
Nasal Prong?	

Tracheostomy

Make:	Size:
Cuffed?	
Other Equipment required for Tracheostomy Care:	

Please tick as appropriate:

Chest Physio Plan? ☐ Yes ☐ No

Under Rapid Response Team? ☐ Yes ☐ No

P.R.P? ☐ Yes ☐ No

Professionals involved with the baby, child or young person:

General Practitioner

GP Name:

Address:

Postcode

Phone Number:

Email:

ICB:

Consultants – please complete for all involved

Consultant 1

Consultant Name:

Speciality:

Hospital:

Phone Number:

Email:

Consultant 2

Consultant Name:

Speciality:

Hospital:

Phone Number:

Email:

Consultant 3

Consultant Name:

Speciality:

Hospital:

Phone Number:

Email:

Consultant 4

Consultant Name:

Speciality:

Hospital:

Phone Number:

Email:

Consultant 5

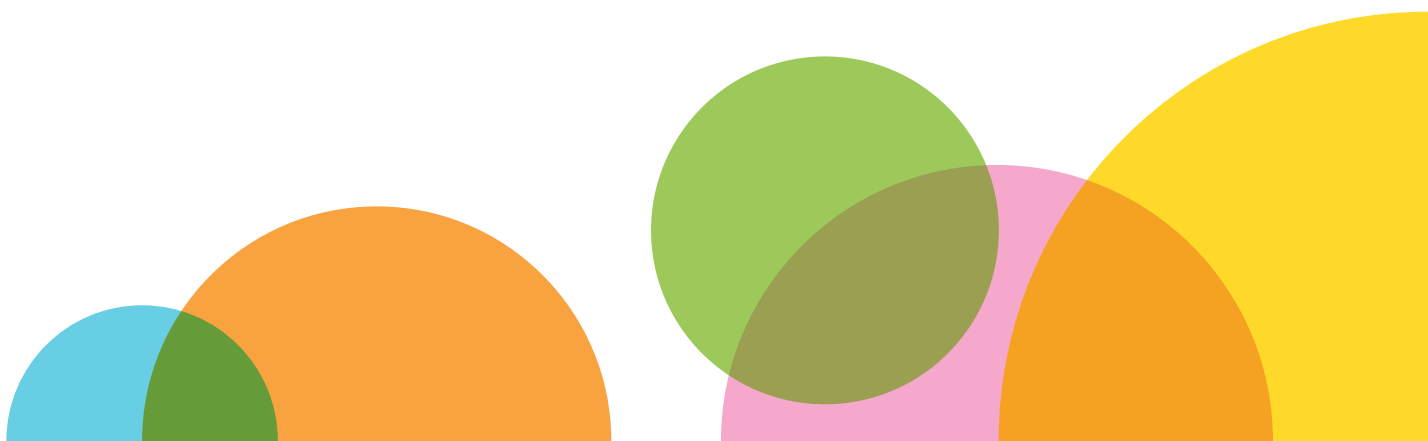
Consultant Name:

Speciality:

Hospital:

Phone Number:

Email:



Other professionals involved – health, education, social care

Professional 1

Name and Role:

Service:

Phone Number:

Email:

Support Offered:

Professional 2

Name and Role:

Service:

Phone Number:

Email:

Support Offered:

Professional 3

Name and Role:

Service:

Phone Number:

Email:

Support Offered:

Professional 4

Name and Role:

Service:

Phone Number:

Email:

Support Offered:

Parent Training?

BLS	☐ Yes	☐ No
Feeding and Use of Feed Pump	☐ Yes	☐ No
NG Tube		
Using?	☐ Yes	☐ No
Replacing?	☐ Yes	☐ No
Set up and checking ventilator?	☐ Yes	☐ No
Set up and checking humidifier?	☐ Yes	☐ No
Set up and checking Saturation monitor?	☐ Yes	☐ No
Oxygen training?	☐ Yes	☐ No
Suction?	☐ Yes	☐ No
Nebuliser?	☐ Yes	☐ No
Cough Assist?	☐ Yes	☐ No

Any other training needs?

Care Team?

Care agency identified?

Carer Training?

BLS	☐ Yes	☐ No
Feeding and Use of Feed Pump	☐ Yes	☐ No
NG Tube		
Using?	☐ Yes	☐ No
Replacing?	☐ Yes	☐ No
Set up and checking ventilator?	☐ Yes	☐ No
Set up and checking humidifier?	☐ Yes	☐ No
Set up and checking Saturation monitor?	☐ Yes	☐ No
Oxygen training?	☐ Yes	☐ No
Suction?	☐ Yes	☐ No
Nebuliser?	☐ Yes	☐ No
Cough Assist?	☐ Yes	☐ No

Any other training needs?

Any other plans or investigations pending?

SALT

Safe Swallow? ☐ Yes ☐ No

If unsafe, feeding method?

Reflux

Sleep Study

Date

Result:

Additional Information Relevant for Referral:

Holistic Assessment

Date of Birth:

Assessment	Notes
Circulatory/Cardiology	
Mobility	
Nutrition and Hydration	
Elimination	
Pain	
Neurological	

Assessment	Notes
Sleeping	
Sensory	
Communication	
Psychological/Emotional	
Play/Education	
Spiritual/Cultural Needs	

Assessment	Notes
Likes/Dislikes	
Other information	

Information From:
Referral completed by?
Date