rainbows
Brightening short lives

We care for babies, children and young people in the East Midlands – wherever they are.

Hospice | Hospital | Home

Referral Form

Please download & save before completion

Child's Details

Surname:	**Forename(s):**
Known As:	**Date of Birth:**
Gender:	**Religion:**
NHS Number:	
Home Address:	
Telephone Number:	

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**

Current Family Details - Parent/Carer 1

Name: | Parental Responsibility? ☐ Yes ☐ No

Home Address (If different to above):

Email:

Phone Number: | Gender:

Religion: | Ethnicity:

Relationship to child:

Do they have a disability?

Main Language:

Interpreter required? ☐ Yes ☐ No | Do they read english? ☐ Yes ☐ No

If not, how do they communicate?

Current Family Details - Parent/Carer 2

Name: | Parental Responsibility? ☐ Yes ☐ No

Home Address (If Different to Above):

Email:

Phone Number: | Gender:

Religion: | Ethnicity:

Relationship to child:

Do they have a disability?

Main Language:

Interpreter required? ☐ Yes ☐ No | Do they read english? ☐ Yes ☐ No

If not, how do they communicate?

If neither of the above have parental responsibility, who does?

Name:

Telephone Number:

Email Address:

Address:

Letters should be addressed to:

Siblings and other household members

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

Additional information such as relevant current family circumstances and other key family members:

Diagnosis and Medical Needs

Diagnosis:

Nursing, Social, Medical Needs and History

Professionals involved with the baby, child or young person:

General Practitioner

GP Name:

Address:

Postcode:

Phone Number:

Email:

ICB:

Consultants

Please complete for all consultants invoved with baby/child/young person

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:

Consultant 6

Consultant Name:

Speciality:

Hospital:

Phone Number:

Email:

Other professionals involved

Please complete for health, education or social care e.g. Social Worker, Health Visitor, Community Children's Nurse, Occupational Therapist or Physiotherapist

Professional 1

Name and Title:

Address:

Phone Number:

Email:

Type and frequency of support and service provided:

Professional 2

Name and Title:

Address:

Phone Number:

Email:

Type and frequency of support and service provided:

Professional 3

Name and Title:

Address:

Phone Number:

Email:

Type and frequency of support and service provided:

Professional 4

Name and Title:

Address:

Phone Number:

Email:

Type and frequency of support and service provided:

Professional 5

Name and Title:

Address:

Phone Number:

Email:

Type and frequency of support and service provided:

Who or what prompted you to make this referral to Rainbows?

Referral to which services?

Short Break Stays	☐ Yes	☐ No
Symptom/Medication Review	☐ Yes	☐ No
Outreach	☐ Yes	☐ No
End-of-Life Care	☐ Yes	☐ No
Family Support	☐ Yes	☐ No
Social Work	☐ Yes	☐ No
Sibling Support (including Bereavement)	☐ Yes	☐ No
Transition/Youth Work	☐ Yes	☐ No
Use of Bereavement Suite	☐ Yes	☐ No
Hospice @ Home (Please follow up with a phone call)	☐ Yes	☐ No

Ethnic Group

White

☐ English/Welsh/Scottish/Northern Irish/British Irish

☐ Gypsy or Irish Traveller

☐ Any Other White Background: _____

Mixed Multiple Ethnic Groups

☐ White and Black Caribbean

☐ White and Black African

☐ White and Asian

☐ Any Other Mixed/Multiple Ethnic Background: _____

Asian or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any Other Asian background: _____

Black/African/Caribbean/Black British

- ☐ African
- ☐ Caribbean
- ☐ Any Other Black, African, Caribbean Background: _____

Other Ethnic Groups

- ☐ Arab
- ☐ Any Other Ethnic Group: _____

It is the referrer's responsibility to provide evidence of medical information (eg recent clinic letters) that supports the child/young person's life limiting condition. Please include as much relevant detail as you can to enable the referral to be processed as quickly as possible.

Please complete seperate Referral Criteria Form

Suppporting documentation sent:

Consent

Have the child's parents (or those with parental responsibility) consented to the referral?

☐ Yes ☐ No

Has the young person consented to the referral (if applicable)?

☐ Yes ☐ No

Rainbows uses a clinical computer system, SystmOne, which lets health staff record patient information securely, onto a computer. This information can be shared with other clinicians so that everyone caring for a patient is fully informed about things like their medical history, allergies and medications.

Referrer

by signing the Referral Form you are confirming this referral has been consented to by the family

Name:

Role:

Job Title (if relevant):

Organisation:

Phone Number:

Email Address:

Signature:

Date:

Additional Information Relevant for Referral: