

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

Hospice | Hospital | Home

Referral Form

Is the child a looked after child?

No

Yes

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:			

Current Family Details - Parent/Carer 1

Name:		Parental Responsibility?	Yes	No
Home Address (If different to abo	ve):			
Email:				
Phone Number:		Gender:		
Religion:		Ethnicity:		
Relationship to child:				
Do they have a disability?				
Main Language:				
Interpreter required? Yes	es No	Do they read english?	Yes	No
If not, how do they communicate	?			
Current Family Details - Par	rent/Car	er 2 Parental Responsibility?	Yes	No
Home Address (If Different to Abo	ove):	• •		
Email:				
Phone Number:		Gender:		
Religion:		Ethnicity:		
Relationship to child:				
Do they have a disability?				
Main Language:				
Interpreter required? Yes	es No	Do they read english?	Yes	No
If not, how do they communicate	?			

Telephone Nu						
Email Address	:					
Address:						
Letters should	be addressed t	o:				
Siblings and	other house	hold me	mbers			
Relationship to child	Sibling Name	Gender	Date of Birth	Date of Death	Same Condition?	Language and Religion if different?
Additional info	ormation such a ers:	s relevant	current fa	mily circum	nstances and c	other key

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

Name:

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:	

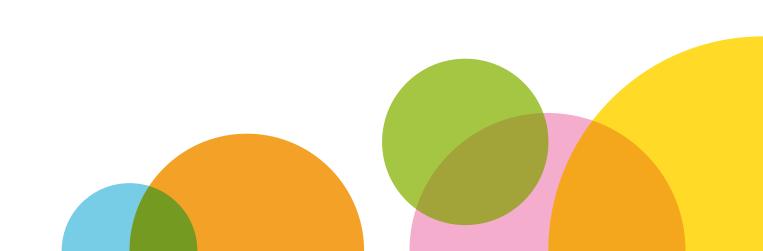


Consultant 4 Consultant Name: Speciality: Hospital: Phone Number: Email: Consultant 5 Consultant Name: Speciality: Hospital: Phone Number: Email: Consultant 6 Consultant Name: Speciality:

Hospital:

Email:

Phone Number:



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:



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:

Professional 3



Who or what prompted you to make this referral to Rainbows?		
Referral to which services?		
	Voc	No
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
Jse 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 **Supporting documentation sent:**

Consent

Have the child's parents (or those with parental responsibility) consented to the referre	have the child's parents (or those with t	parental responsibility	y) consented to	the referrors
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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:	

