



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

<b>Surname:</b>	<b>Forename(s):</b>
<b>Known As:</b>	<b>Date of Birth:</b>
<b>Gender:</b>	<b>Religion:</b>
<b>NHS Number:</b>	
<b>Home Address (including Postcode):</b>	
<b>Telephone Number:</b>	

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

<b>Social Worker Name:</b>	<b>Contact Number:</b>
<b>Email Address:</b>	

Is the child a looked after child?

**Yes**

**No**



## Current Family Details - Parent/Carer 1

<input type="text"/>	<b>Name:</b>	<input type="checkbox"/>	<b>Parental Responsibility?</b>	<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>				
<input type="text"/>											
<b>Home Address (including Postcode) - If different to above:</b>											
<input type="text"/>											
<b>Email:</b>											
<input type="text"/>											
<input type="text"/>	<b>Phone Number:</b>	<input type="text"/>	<b>Gender:</b>								
<input type="text"/>	<b>Religion:</b>	<input type="text"/>	<b>Ethnicity:</b>								
<input type="text"/>											
<b>Relationship to child:</b>											
<input type="text"/>											
<b>Do they have a disability?</b>											
<input type="text"/>											
<b>Main Language:</b>											
<input type="text"/>											
<input type="checkbox"/>	<b>Interpreter required?</b>	<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	<b>Do they read english?</b>	<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>
<input type="text"/>											

## Current Family Details - Parent/Carer 2

<input type="text"/>	<b>Name:</b>	<input type="checkbox"/>	<b>Parental Responsibility?</b>	<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>				
<input type="text"/>											
<b>Home Address (including Postcode) - If different to above:</b>											
<input type="text"/>											
<b>Email:</b>											
<input type="text"/>											
<input type="text"/>	<b>Phone Number:</b>	<input type="text"/>	<b>Gender:</b>								
<input type="text"/>	<b>Religion:</b>	<input type="text"/>	<b>Ethnicity:</b>								
<input type="text"/>											
<b>Relationship to child:</b>											
<input type="text"/>											
<b>Do they have a disability?</b>											
<input type="text"/>											
<b>Main Language:</b>											
<input type="text"/>											
<input type="checkbox"/>	<b>Interpreter required?</b>	<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	<b>Do they read english?</b>	<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>
<input type="text"/>											

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

**Name:**

**Telephone Number:**

**Email Address:**

**Home Address (including Postcode):**

**Letters should be addressed to:**

### Siblings and other household members

Relationship to child	Sibling Full 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 involved with baby/child/young person

### Consultant 1

Consultant Name:

Speciality:

Hospital:

Address:

Postcode:

Phone Number:

Email:

### Consultant 2

Consultant Name:

Speciality:

Hospital:

Address:

Postcode:

Phone Number:

Email:



### Consultant 3


<b>Consultant Name:</b>	
<b>Speciality:</b>	
<b>Hospital:</b>	
<b>Address:</b>	
<b>Postcode:</b>	<b>Phone Number:</b>
<b>Email:</b>	

### Consultant 4

<b>Consultant Name:</b>	
<b>Speciality:</b>	
<b>Hospital:</b>	
<b>Address:</b>	
<b>Postcode:</b>	<b>Phone Number:</b>
<b>Email:</b>	

### Consultant 5

<b>Consultant Name:</b>	
<b>Speciality:</b>	
<b>Hospital:</b>	
<b>Address:</b>	
<b>Postcode:</b>	<b>Phone Number:</b>
<b>Email:</b>	



## 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:

Postcode:

Phone Number:

Email:

Type and frequency of support and service provided:

### Professional 2

Name and Title:

Address:

Postcode:

Phone Number:

Email:

Type and frequency of support and service provided:



### Professional 3

Name and Title:

Address:

Postcode:

Phone Number:

Email:

Type and frequency of support and service provided:

### Professional 4

Name and Title:

Address:

Postcode:

Phone Number:

Email:

Type and frequency of support and service provided:

### Professional 5

Name and Title:

Address:

Postcode:

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 separate Referral Criteria Form**

**Supporting 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:**

**Address:**

**Postcode:**

**Phone Number:**

**Email Address:**

**Signature:**

**Date:**



**Additional Information Relevant for Referral:**

