rainbows
Brightening short lives

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

Hospice | Hospital | Home

Neonatal Care Referral Form

Please **download and save** before completion

Child's Details

Surname:	**Forename(s):**
Known As:	**Date of Birth:**
Gender:	**Religion:**
Ethnicity: Please select	**NHS Number:**

Address *(Including Postcode)*:

Location of Neonatal Unit:

Diagnosis

Information About Their Current Condition:

What Is the Baby's Current Condition? *(Tick as appropriate)*

☐ Stable ☐ Unstable ☐ Deteriorating ☐ Dying

Current Family Details - Parent/Carer 1

First Name: | Surname:

Home Address (including Postcode) - If different to above:

Email:

Phone Number: | Mobile Number:

Religion: | Gender:

Relationship to child: | Ethnicity: Please select

Do they have a disability?

Main Language: | Parental Responsibility? ☐ Yes ☐ No

Interpreter required? ☐ Yes ☐ No | Able to read English? ☐ Yes ☐ No

Communication requirements:

Current Family Details - Parent/Carer 2

First Name: | Surname:

Home Address (including Postcode) - If different to above:

Email:

Phone Number: | Mobile Number:

Religion: | Gender:

Relationship to child: | Ethnicity: Please select

Do they have a disability?

Main Language: | Parental Responsibility? ☐ Yes ☐ No

Interpreter required? ☐ Yes ☐ No | Able to read English? ☐ Yes ☐ No

Communication requirements:

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

First Name:	Surname:
Phone Number:	Mobile Number:

Email Address:

Home Address (including Postcode):

Letters should be addressed to:

Siblings and other household members

Relationship to Child	Sibling Full Name (First/Last Name)	Gender	D.O.B.	D.O.D	Same Condition?	Language and Religion If Different?	Same Address?

**Full/Half/Adopted/Step*

Have This Family Had Any Babies, Children or Young People Die From the Same or Any Other Condition?:

☐ Yes ☐ No

Additional Information such as Relevant Current Family Circumstances and Other Key Family Members:

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

☐ **Yes** ☐ **No**

If Yes, Please Give Brief Details Including Social Worker Name and Contact Details:

Social Worker Name:

Mobile: **Telephone:**

Email:

Is the Child a Looked After Child?: ☐ **Yes** ☐ **No**

Professionals Involved with the Baby

General Practitioner

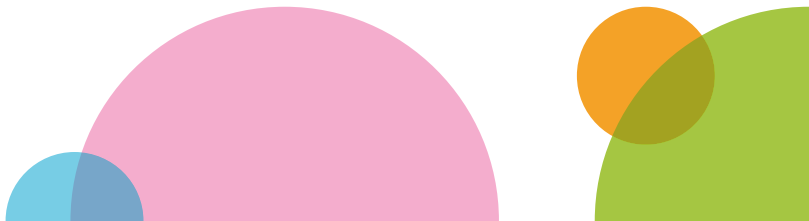
GP Name:

Address *(Including Postcode)*:

Mobile: **Telephone:**

ICB:

Email:



Consultants

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

Consultant 1

Consultant Name:

Speciality:

Hospital:

Address *(Including Postcode)*:

Mobile:

Telephone:

Email:

Consultant 2

Consultant Name:

Speciality:

Hospital:

Address *(Including Postcode)*:

Mobile:

Telephone:

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:

Title:

Address *(Including Postcode)*:

Email:

Mobile:

Telephone:

Type and Frequency of Support and Service Provided:

Professional 2

Name:

Title:

Address *(Including Postcode)*:

Email:

Mobile:

Telephone:

Type and Frequency of Support and Service Provided:

Consent

Have the Child's Parents (Or Those With Parental Responsibility) Consented to the Referral?:

☐ **Yes** ☐ **No**

Rainbows uses a clinical computer system, SystmOne, which lets health professionals 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 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:	
Job Title:	
Organisation:	
Address *(Including Postcode)*:	
Mobile:	**Telephone:**
Email:	
Date:	**Signature:**

Referral Criteria

Please indicate which group the child or young person fits into:

☐ **Group 1 - Neonatal**

Premature 22-25 weeks gestation or Premature 26-28 weeks gestation with other risk factors such as growth restriction

☐ **Group 2 - Neonatal**

Cardiac diagnosis

☐ **Group 3 - Neonatal**

Newborn infants with brain injury and high risk of severe disability e.g. Sarnat III hypoxicischaemic encephalopathy, severe intra-ventricular haemorrhage. Conditions requiring intensive therapies and/or interventions to sustain or prolong life.

☐ **Group 4 - Neonatal**

Post-natal exome sequencing indicates diagnosis with the potential to lead to death in early childhood

NB: As part of the neonatal criteria, families and babies will be offered music therapy, complementary therapy, family support by the local Clinical Nurse Specialists (CNSs), Symptom management plans, advanced care planning and end-of-life care (EOLC) if needed. At the point of discharge, a holistic needs assessment will be carried out to establish the ongoing need of the baby and family. This may result in being discharged from the service. Memories in heartbeat requires a different referral process and the baby needs to meet EOLC criteria.

Memories In Heartbeat Criteria: Any baby expected to die during pregnancy, at delivery, or shortly after birth due to a life-limiting condition should have a good-quality, one-minute heartbeat recording obtained during a foetal scan using voice notes.

If you think the baby meets the criteria, please email your local Rainbows Clinical Nurse Specialists:

- **QMC - elisa.monk@rainbows.co.uk**
- **LRI - clementine.ashcroft@rainbows.co.uk**
- **ACP - jane.lewins@rainbows.co.uk**

They will complete a referral on SystmOne on your behalf. Please obtain consent from the family to access their S1 records and record data on there, which is shared with other Community Teams.

Please make the family aware that they will be contacted by Rainbows Music Therapist to discuss.

Additional Information Relevant for Referral:

Please save the completed form and send to **referrals@rainbows.co.uk**