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 and save** before completion

Child's Details

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

Home Address (including Postcode):

Telephone Number:

Diagnosis and Medical Needs

Diagnosis:

Nursing, Social, Medical Needs and History

What is the baby, child or young person's current condition?

☐ **Stable** ☐ **Unstable** ☐ **Deteriorating** ☐ **Dying**

Would you be surprised if the baby, child or young person you are referring died in the next 12 months?

☐ **Yes** ☐ **No**

Current Family Details - Parent/Carer 1

First Name:

Surname:

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

Email:

Phone Number:

Gender:

Religion:

Ethnicity: Please select

Relationship to child:

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:

Gender:

Religion:

Ethnicity: Please select

Relationship to child:

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?

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 (First/Last Name)	Gender	D.O.B	D.O.D	Same Condition?	Language and Religion if different?	Same Address?

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 & contact details

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

Is the child a looked after child?

☐ Yes ☐ No

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

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:	
Address:	
Postcode:	**Phone Number:**
Email:	

Consultant 2

Consultant Name:	
Speciality:	
Hospital:	
Address:	
Postcode:	**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:

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:

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.

Suppporting documentation sent:

Is the baby, child or young person currently accessing another hospice?

☐ **Yes** ☐ **No**

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.

If the referral is for an adult who is unable to consent to the referral, please attach your Mental Capacity Assessment and Best Interest Decision.

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:

Referral Criteria

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

Does the child/young person you are referring meet the Rainbows criteria?

☐ **Yes** ☐ **No**

☐ **Life-threatening Conditions**

- conditions for which curative treatment may be feasible but carry a high risk of failure.
- conditions requiring intensive therapies and/or interventions to sustain or prolong life.

☐ **Life-limiting Conditions**

- conditions where death in childhood is likely due to the progressive nature of the condition or where there is no curative treatment option.

☐ Medical Complexity

- conditions causing severe neurological impairment and associated complex comorbidities which mean death in childhood is likely or which increase susceptibility to life-threatening events.

Please state:

Additional Information Relevant for Referral:

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