**Children’s Community Nursing West Referral Form**

**Part 1**

This form must be completed by a health care professional. Please complete and send the form and return to the email address at the end of the form:

**Please DO NOT discharge the patient from your service until CCN team have accepted.**

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| --- | --- | --- | --- | --- |
| **Name:**  Male/Female | | | **D.o.B:** | |
| **NHS number:** | | | **Named Consultant:** | |
| **Parent or Carer’s name:**  **Relationship to the child:** | | | **Home address:**  **Postcode:** | |
| **Contact numbers for parents/carers**  **Landline:**  **Mobile:**  **Email:** | | | **GP:**  **Number:** | |
| **Heath visitor:**  **Contact number:** | | | **Social worker:**  **Contact number:** | |
| **Main language:**  **Is an interpreter required? Yes/ No** | | | **Faith group:**  **Ethnic origin:** | |
| **Medication:** | | | **Allergies/intolerances:** | |
| **Reason for referral:**  **Estimated date for discharge:** | | | **Medical history/ known conditions:** | |
| **Baseline observations:**  HR………  B/P………  RR……….  Sats……….. | | | | |
| **Breathing and Circulation:**  Oxygen requirement: Y / N  Litres/min:  Cylinders:  Concentrator:  Face mask: Y / N (type and size)  Nasal cannula: Y / N | | | | |
|  | **Last Resus Training (date):** | | **HOOF Y/N**  **Oxygen pathway completed Y/N** | |
| **Nutrition : Referral to Dietician: Y/N N/A**  Breast: Y / N  Bottle: Y / N  Naso- Gastric: Y / N (If Y please state size of NG): Size:  **Can NG tube be repassed in the home Y/N**  Gastrostomy: Y / N  Jejunostomy: Y / N  Parenteral feeding: Y / N  Type and frequency of feed/feeding plan (mls/kg):  Abbott E-Reg completed: Y/N | | | | |
| **Parental Competencies:**  **Please list any competencies obtained/outstanding:**  **Competencies attached with referral: Y/N To be sent:** | | | | |
| **Wound Care Specific: Nature of wound:**  **Wound care required:**  **Type of dressings/current care plan:**  **Referral to Tissue Viability Y/N N/A Podiatry if below ankle Y/N** | | | | |
| **Skin/Wound:**  Significant marks Y / N  If Y please note:  Mongolian Blue spot: Y / N | | | **Equipment/Dressings:** **(ordered supplied)** | |
| **Are there any safeguarding concerns or safeguarding history?**  **Are there any risks to visiting the child’s home?** | | | **Source of Referral (ward, consultant, other professional):**  **Contact number:**  **Name of referring person:**  **Signature of referring person:**  **Date** | |
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| **Please return this referral form by secure email to the email address below:**  For Berkshire West: [ccnwest@berkshire.nhs.uk](mailto:ccnwest@berkshire.nhs.uk) |

**Incomplete referrals will be returned**

**Children’s Community Nursing Referral/discharge Form**

**Part 2**

Please keep CCN team informed when patient is discharged home.

On discharge, please ensure the following has been completed and this form emailed to the CCN Team: [ccnwest@berkshire.nhs.uk](mailto:ccnwest@berkshire.nhs.uk)

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| --- | --- | --- | --- |
| **DISCHARGE CHECK LIST** | **YES** | **NO** | **N/A** |
| **CCN referral form completed, emailed & accepted: named CCN: ……………………** |  |  |  |
| **TTOS (including Milk feeds, hepsal/saline & dressings)** |  |  |  |
| **Plastics (NG tube, giving sets, syringes etc at least one week supply)** |  |  |  |
| **Copy of parent competencies for CCN** |  |  |  |
| **Pink BHFT Prescription Chart for CCN** |  |  |  |
| **Open Access Letter to RBH/ED** |  |  |  |
| **Equipment ordered/supplied** |  |  |  |
| **Additional: please list** |  |  |  |

**Referral Reference Guide**

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| --- | --- |
| **Nursing Need** | **Additional** |
| **Naso Gastric feeds** | 1. Referral to inpatient dietician 2. Parent/carer NG competencies (copy for CCN) 3. Abbott e-reg set up (dieticians will assist/advice) 4. If applicable Abbott pump training: 0800 0183799 5. At least 1 week supply of plastics, milk etc from Ward |
| **Oxygen dependant** | 1. Please commence Home Oxygen pathway: RBH intranet 2. Ward to arrange HOOF, Risk Assessment & oxygen home delivery (Dolby website: www.dolbyvivisol.com .   **Need at least 24 hours notice unless emergency.**   1. BLS training for parents/carers 2. Oxygen competencies to be completed (copy for CCN) 3. Oxygen escalation plan if required |
| **Equipment** | If the patient requires equipment at home please contact CCN ASAP to help arrange. NB: Equipment can take several weeks to set up. |
| **Short/Long term IVAB** | 1. Make contact with CCN ASAP so we can assist with home set up. **Need at least 24 hours notice** 2. IVAB infusions can only be administered via a central access device in the community 3. Liaise with inpatient pharmacy to assist with home care delivery and prescriptions. 4. Complete CCN prescription form |
| **Wound dressings** | 1. Clear instructions on referral form 2. Adequate supply of dressings (at least one week) 3. Contact details of named Consultant and medical/surgical team patient is under. |