

**Children’s Community Nursing Referral Form**

***This form must be completed by a Health Care Professional.***

**CCN Team East Referral Criteria**

**\*Nursing need**

**&**

 **\*Learning disability OR Complex needs with mainly community service input.**

**&**

**\*East Berks GP OR one of the following South Bucks GP.**

**(\*Iver Medical Centre, \*Iver Heath Health Centre, \*Burnham Health Centre, \*Southmead Surgery, \*Three ways Surgery, \*The Hawthornden Surgery, \*Denham Medical Centre, \*Denham Green Surgery, \*South Bucks.).**

**Please complete 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:**  |
| **Main Carer’s name:** **Relationship to the child:** | **Home address:****Postcode:** |
| **Main Language:** | **Is an interpreter required? Yes/ No** |
| **Contact numbers for parents/carers.** **Landline:****Mobile:****Email:** | **GP:****Number:** |
| **Heath visitor:****Contact number:** | **Social worker:****Contact number:** |
| **Medication:** | **Allergies/intolerances:** |
| **Reason for referral:** |
| **Medical history/ known conditions:**  |
| **Estimated date for discharge:** | **Date of last BLS Training:** **(if required).**  |
| **Oxygen Needed Y/N** | **HOOF Completed Y/N****If YES copy to be given to CCN.** |
| **Nutrition: Referral to Dietician: Y/N N/A****Naso- Gastric: Y / N (If Y please state size of NG): Size:** **Can NGT be re-passed at home? Y / N****Gastrostomy: Y / N****Jejunostomy: Y / N****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 or N/A** **Podiatry if below ankle 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 to the below email address:****Berkshire East:** **ccneast@berkshire.nhs.uk****Incomplete referrals will be returned.**  |