A close-up of a logo

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**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**](mailto:ccneast@berkshire.nhs.uk)  **Incomplete referrals will be returned.** |