**Children’s Community Nursing Referral Form**

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

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| **Name:**  Male/Female | | | **Date of birth:** | | |
| **NHS number:**  **MRN:** | | | **Named consultant:** | | |
| **Parent or carer’s name:**  **Relationship to the child:** | | | **Home address:**  **Postcode:** | | |
| **Contact details for parent/carer**  **Landline:**  **Mobile:**  **Email:** | | | **GP:**  **Contact 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:**  **Does the CYP have a Learning Disability? Y/N** | | |
| **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** | | | | | |
| Breast: | Y/N | | Type and frequency of feed/feeding plan (mls/kg): | |  |
| Bottle: | Y/N | |
| Gastrostomy: | Y/N | |
| Jejunostomy: | Y/N | |
| Parenteral feeding: | Y/N | |
| **Elimination** | | | | | |
| Independent: | Y/N | | Catheter:  Size: | | Y/N |
| Assistance: | Y/N | |
| Dependant nappies:  Size of pad: | | Y/N |
| Stoma: | Y/N | |
| **Neurological (seizure, brain injury)** | | | | | |
| **Skin/Wound** | | | **Equipment/Dressings:** **(ordered supplied)** | | |
| Significant marks:  If yes please note: | | Y/N |
| Mongolian Blue spot: | | Y/N |
| **Is there any safeguarding concerns or safeguarding history?** | | | **Are there any risks to visiting the child’s home?** | | |

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| **Source of referral (ward, consultant, other professional):** |  |
| **Name of referring person:** |  |
| **Contact number:** |  |
| **Signature of referring person:** |  |
| **Date:** |  |

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| **Please return this referral form by secure email to the appropriate address below which are suitable for sending sensitive and confidential information securely.**  For Berkshire West: [ccnwest@berkshire.nhs.uk](mailto:ccnwest@berkshire.nhs.uk)  For Berkshire East: [ccneast@berkshire.nhs.uk](mailto:ccneast@berkshire.nhs.uk)  **Please Note the criteria for CCN East:** child/young person has a learning disability coupled with complex health/nursing need. |