**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.

|  |  |
| --- | --- |
| **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/NLitres/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?** |

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

|  |
| --- |
| **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.ukFor Berkshire East: ccneast@berkshire.nhs.uk **Please Note the criteria for CCN East:** child/young person has a learning disability coupled with complex health/nursing need.  |