Referral Form – Hospice in the Weald Children & Young People's Service

Email: hitw.hospice@nhs.net or call 01892 820515

Child/Young Person's Name		Child/Young Person's Surname	
Date of Birth		Sex	**Male ☐ Female ☐**
NHS Number			
Family Address		Postcode:	
		Tel No:	
		Mobile No:	
		Email:	

Parent/Carer details

First Name	Surname	Title	DOB	Relationship to child/young person	Parental responsibility Y/N	Address if different from above

Details of shared care arrangements (if applicable)	

Sibling Details

First Name	Surname	Date of Birth	Gender	Relationship to the child/young person

Please call 01892 820 515 for further information
Please email the completed form to hitw.hospice@nhs.net

Other Significant others

First Name	Surname	Relationship to the child/ young person

Language spoken	
Is an interpreter required?	

Ethnic background:

White	Asian/Asian British	Black African/Black Caribbean/Black British
English, Welsh, Scottish, Northern Irish or British ☐ Irish ☐ Gypsy or Traveller ☐ Roma ☐ Other White background ☐	Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Other Asian background ☐	African ☐ Caribbean ☐ Other Black, Black British, or Caribbean background ☐
Mixed or multiple ethnic groups	**Other ethnic group**	
White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Other mixed or multiple ethnic background ☐	Arab ☐ Any other ethnic group ☐	

Religion:

Christian (Catholic, protestant or any other Christian denominations) ☐	Sikh ☐
Buddhist ☐	No religion ☐
Hindu ☐	Any other religion (Please specify) ☐
Muslim ☐	
Jewish ☐	___________________________________

Consent to referral and to seek and share information

For the Hospice in the Weald Children and Young People's Service to provide safe and effective care we will need to obtain or share your child/young person's general medical and social care information including clinic letters, copies of prescriptions, emergency care plans and advanced care plans from other professionals. Please note we will not be able to progress with the referral until written consent is received.

I parent/guardian give consent to the referral Yes ☐ No ☐

Print Name ______________________________

Signature ______________________________

Date ______________________________

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For young people over the age of 16.

Does this young person have capacity to consent to the referral? Yes ☐ No ☐

If so, has consent to the referral been given? Yes ☐ No ☐

Diagnosis and medical background, including allergies (please attach any relevant medical summaries)

Does the child/young person have an

Advanced Care plan? Yes ☐ No ☐
Symptom Management plan? Yes ☐ No ☐

Please give a brief description of the reason for the referral. How do you feel the Hospice in the Weald Children and Young People's Service could support the child/young person and family?

- Care at Home sessions
- Stay and play
- After school club
- Holiday Club
- Counselling support

Please tell us if the child/young person is subject to child protection plan or child in need plan: Yes ☐ No ☐

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Are there any other safeguarding concerns we should be aware of (including any risks that we need to be aware of and any contact restrictions)

Professional details

Name of professional	Role	Telephone No:	Email address/ address
	Specialist consultant		
	CCN Team		
	Social worker		
	Health Visitor		
	Therapist		
	Other		

GP Details

Name	Name and Address of Surgery	Telephone Number and Email

School details:

Contact Name and Position	Name and Address of School	Telephone Number and Email

Referrer's details:

Name		Job Title & Organisation	
Tel No		Email	
Signature		Date	

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Appendix 1: Referral Criteria

Referral Criteria for Children and Young People with life limiting and life-threatening conditions as defined by Together for Short Lives under the four definition Categories, with additional scope under Category 4 with further assessment**.**

Category	Description
Category 1	**Children with life threatening conditions for which curative treatment may be feasible but can fail. Access to palliative care services may be necessary when treatment fails or during an acute crisis.**
Category 2	**Conditions where premature death is inevitable. There may be long periods of intensive treatment aimed at prolonging life and allowing participation in normal activities. Examples cystic fibrosis, Duchenne muscular dystrophy.**
Category 3	**Progressive conditions without curative treatment options.** **Treatment is exclusively palliative and may extend over many years Examples: Batten disease, mucopolysaccharidosis.**
Category 4	**Irreversible but non-progressive conditions causing severe disability leading to susceptibility to health.** **Examples: Severe cerebral palsy, multiple disabilities such as following brain or spinal cord injury.**

A further assessment may be required for a category 4 diagnosis

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