**Referral Form**

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| Date of referral: |  | Time of referral: |  |

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| Is the family new to the services of Jigsaw Children’s Hospice | Y/N |
| Is this a re-referral to Jigsaw Children’s Hospice | Y/N |

**What service would you like from Jigsaw Childrens Hospice:**

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| End of Life Care | Short breaks/ Respite stays | Day Care | Family support |
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| **Patient Details** | | | | | | |
| Name: | | Date of Birth: | | | Gender: | |
| Ethnic Group: | | Religion: | | | Main Language: | |
| Address: | | | Telephone Numbers: | | | |
| E-mail addresses: | | | | | | |
| **Family Details** | | | | | | |
| **Carer 1:** |  | | | **Carer 2:** | |  |
| Relationship to child: |  | | | Relationship to child: | |  |
| Title: |  | | | Title: | |  |
| Full Name: |  | | | Full Name: | |  |
| Marital Status: |  | | | Marital Status: | |  |
| Parental Responsibility: |  | | | Parental Responsibility: | |  |
| Next of Kin: |  | | | Next of Kin: | |  |
| E-mail address: |  | | | E-mail address: | |  |
| Telephone number: |  | | | Telephone number: | |  |
| Address if different to above: |  | | | Address if different to above: | |  |
| Are the parent/carer aware of the referral request: |  | | | Are the parent/carer aware of the referral request: | |  |
| Are they happy to receive e-mails? |  | | | Are they happy to receive e- mails? | |  |
| Can both contacts receive correspondence? | | | | Yes/No- If no please specify: | | |

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| **Past Medical History** |
|  |
| **What are the child / young person's current care needs?**  **Including Nursing, Medical, Social, Sensory and Spiritual Needs**  i.e. what care are they receiving now and from whom? |
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| **What support would you like from Jigsaw / Any other information to share** |
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| Referrer’s Details | | | | | | | |
| Name |  | | | Title |  | | |
| Address |  | | | | | | |
| Contact Number | | |  | | | | |
| E-Mail | | |  | | | | |
| Has the person with parental responsibility consented to the referral? | | | | | | Yes | No |
| Has the young adult or parent/s given consent to view and share medical records/Information? | | | | | | Yes | No |
| Signature | |  | | | | | |
| Print | |  | | | | | |
| Date | |  | | | | | |

**Professionals involved with child/young person.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Do you have?** | **Profession** | **Name** | **Address** | **Telephone** | **E-mail** |
| Y N | GP |  |  |  |  |
| Y N | Consultant |  |  |  |  |
| Y N | Consultant |  |  |  |  |
| Y N | Community Nurse |  |  |  |  |
| Y N | Social Worker |  |  |  |  |
| Y N | Physio |  |  |  |  |
| Y N | OT |  |  |  |  |
| Y N | Speech & Language |  |  |  |  |
| Y N | Health Visitor |  |  |  |  |
| Y N | Specialist Nurse |  |  |  |  |
| Y N | School/Nursery |  |  |  |  |
| Y N | Dietician |  |  |  |  |
| Y N | Epilepsy Nurse |  |  |  |  |
|  | **Other** |  |  |  |  |
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