**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** |
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| **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.**

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| --- | --- | --- | --- | --- | --- |
| **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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