**EPUT Children’s Community Nursing Team**

**Referral Form**

Please return by email to: [epunft.ccn@nhs.net](mailto:epunft.ccn@nhs.net)

Telephone: 0344 257 3956 or 07966 792396

**No handwritten forms will be accepted - only this electronic form. Incomplete forms will be returned.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT DETAILS** | | | | | | | | | | | | | | | | | | |
| NHS Number | | | |  | | | | | | |  | | | | | | | |
| Surname | |  | | | | | | | First Name | | |  | | | Title | |  | |
| Date of Birth | | |  | | | | | Gender *(indicate Male or Female)* | | | | |  | | | | | |
| Address |  | | | | | | | | | | | | | Postcode |  | | | |
| Parent/Carer Full Names | | | | | |  | | | | | | | | | | | | |
| Parent/Carer Contact Number | | | | | | |  | | | Has parent consented to referral *(indicate Yes or No)* | | | | | | | |  |
| Spoken Language | | | | |  | | | | | | | Interpreter required *(indicate Yes or No)* | | | |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **REFERRER’S DETAILS** | | | |
| Referee Name |  | Designation |  |
| Unit Name |  | Hospital Name |  |
| Date of referral |  | Contact Number |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **REASON FOR REFERRAL***(see separate referral criteria)* | | | | | | | |
| **List past medical history, history of illness & treatment** (enclose copies of medical letters, blood and investigation results) | | | | | | | |
|  | | | | | | | |
| **Please specify nursing intervention required** | | | | | | | |
|  | | | | | | | |
| **If referring for IVAB please list** | | | | | | | |
| **Antibiotic/Medication** | | |  | **Dose** |  | **mg/kg** |  |
|  | | | | | | | |
| 1. |  | |  |  |  |  |  |
| \ | | | | | | | |
| 2. |  | |  |  |  |  |  |
|  | | | | | | | |
| **Allergies (please list all known allergies)** | | | | | | | |
|  | | | | | | | |
| Allergy Medications *(please list)* | |  | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **OBSERVATIONS ON DISCHARGE** | | | | | | | | | | | | | |
| HR |  | RR |  | BP |  | SATS |  | TEMP |  | PEWS |  | WEIGHT |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **If HSP, please provide parameters** | | | |
| Age accepted parameters |  | If no parameters, provide guidance |  |

|  |
| --- |
| **MEDICATION ON DISCHARGE** *(please state)* |
|  |

|  |  |
| --- | --- |
| **DISCHARGE DATE** *(if within 24 hours please call PCN Team to discuss prior to discharge)* |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CONSULTANT’S DETAILS** | | | | | |
| Hospital Number |  | Consultant |  | Contact No |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SAFEGUARDING/RISK ASSESSMENT** | | | | | |
| Subject to Child Protection Plan | |  | Known to Social Care |  | |
| Child in Need Plan | |  | Any pets at home |  | |
| If pets, please state |  | | | |  |
| Any concerns regarding family/home that may affect staff safety: | | | | | |
|  | | | | | |

**Wound Care**

**NB: First dressings must be undertaken on Ward if wound has been packed in theatre**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WOUND DRESSINGS** *(Please supply dressings and copy of operation notes, if available)* | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Wound site |  | | | | Type of wound | | | |  | | | |  | | |
|  | | | | | | | | | | | | | | | |
| Date of surgery/Injury | |  | | Size | |  | | | | | | Depth |  | |  |
|  | | | | | | | | | | | | | | | |
| Dressings used | |  | | | Date last dressed | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | |
| Packing required | |  | Length of packing used | | | |  | | | | Analgesia required | | |  | |
|  | | | | | | | | | | | | | | | |
| How frequently are dressing changes required *(mark as appropriate)* | | | | | | | |  | | | | |  | | |
|  | | | | | | | | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **CONSUMABLES DISCHARGED WITH PATIENT** | | |
| Wound care *(enough dressings for 5 days taking into account hospital discharges if at weekend)* |  |  |

**Enteral Feeding**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TYPE OF DEVICE** *(Place tick in correct box)* | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Device Type | |  | | Size |  | | Date inserted | |  | | Feeds type | |  | | |
|  | | | | | | | | | | | | | | | |
| Tube type |  | | Tube changed | | |  | | Tube size | |  | | Date tube passed | |  | |
|  | | | | | | | | | | | | | | | |
| Post-op Instructions/Care | | | |  | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Dietician |  | Contact Number |  |

|  |
| --- |
| **FEED AND EQUIPMENT** *(Place tick in correct box)* |
|  |
| Patient set up on Fresenius Kabi by Dietician? |
|  |
| Is at least one parent signed off competent to administer feeds/medication? *(Send Competencies to PCN Team)* |
|  |
| Have all supplies been ordered/supplied for at least 7 days post-discharge? |

|  |  |  |  |
| --- | --- | --- | --- |
| **CONSUMABLES/EQUIPMENT DISCHARGED WITH PATIENT** | | | |
| Enteral feed/equipment – 5 days’ worth | |  |  |
| Other *(please state)* |  | | |