**EPUT Children’s Community Nursing Team**

**Referral Form**

Please return by email to: 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.**

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| **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)* |  |

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

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

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

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

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

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

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| **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: |
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**Wound Care**

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

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| **WOUND DRESSINGS** *(Please supply dressings and copy of operation notes, if available)*  |
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| Wound site |  | Type of wound |  |  |
|  |
| Date of surgery/Injury |  | Size |   | Depth |  |  |
|  |
| Dressings used |  | Date last dressed |  |
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| Packing required |  | Length of packing used |  | Analgesia required |  |
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| How frequently are dressing changes required *(mark as appropriate)*  |  |  |
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| **CONSUMABLES DISCHARGED WITH PATIENT**  |
| Wound care *(enough dressings for 5 days taking into account hospital discharges if at weekend)* |  |  |

**Enteral Feeding**

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

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

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