**CHILD BLOOD TEST REFERRAL FORM**

**Non-Urgent Tests only**

**Please note this service is only for Children and Young People (CYP) who have additional needs that mean that there are challenges faced when taking bloods in a GP surgery.**

**All urgent requests should be directed to the hospital and routine non-urgent requests for blood tests on CYP without a degree of complexity should be redirected to the service that provided phlebotomy prior to COVID.**

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| --- | --- | --- | --- |
| **CHILD’S NAME:** | | **NHS NUMBER:** |  |
| **ADDRESS:** | | **DATE OF BIRTH:** |  |
| **CONTACT NUMBERS:** |  |
| **REGISTERED GP /**  **CONSULTANT:** |  | **NAME OF GUARDIAN:** |  |
| **RELATIONSHIP:** |  |
| **GP PRACTICE /**  **HOSPITAL** |  | **REFERRING CLINICIAN**  **Contact details:** |  |
|  | | | |
| **REFERRAL DATE:** |  | | |
| **REASON WHY TEST CANNOT BE CARRIED OUT ROUTINELY or RELEVANT CLINICAL HISTORY:** |  | | |
| **PLEASE LIST BLOOD TESTS REQUIRED:** |  | | |
| **HAVE ANY ATTEMPTS ALREADY BEEN MADE TO OBTAIN SAMPLE AND IF SO WHAT CHALLENGES WERE ENCOUNTERED?** |  | | |
| **IS SPECIFIC DATE REQUIRED?** | *(eg. 6 weeks post initiation of treatment)* | | |

**(VENOUS SAMPLES only) Please prescribe local anaesthetic EMLA cream x 2**

**Please email to:** [cfhd.devonspa@nhs.net](mailto:cfhd.devonspa@nhs.net) **Telephone contact:** 03300 245321