**Community Children’s Nursing Pathway
Referral Form**

**For Community Nursing Support - complete Part 1 and Part 2**

**For Blood Test - complete Part 1 and Part 3**

**PART 1 - Information about the child / young person**

|  |  |
| --- | --- |
| Surname |  |
| Forenames |  |
| Preferred name |  |
| Date of Birth |  |
| NHS Number (if known) |  |
| Ethnicity | *We ask this information to enable us to monitor whether our services are being accessed by all sections of our communities:* |
| Nationality |  |
| Religion |  |
| Sex at birth | Male [ ]  | Female [ ]  |
| Gender identity |  |
| Pronouns |  |
| Preferred Language |  |
| Interpreter needed | Yes [ ]  | No [ ]  |
| Address |  |
| Postcode |  |
| Young Person’s Tel (home / mobile) |  |
| Young Person’s Email |  |
| Young Person’s preferred way(s) of communication | Phone [ ]  | Email [ ]  | Post [ ]  | Other [ ]  |
| Parent / Carer Tel (home / mobile) |  |
| Parent / Carer preferred way(s) of communication | Phone [ ]  | Email [ ]  | Post [ ]  | Other [ ]  |
| Has the child / young person been referred to CFHD in the past | Yes [ ]  | No [ ]  | Unsure [ ]  |
| If **YES** please provide details |  |
| **Main Carer(s)** | Parent [ ]  | Mother [ ]  | Father [ ]  | Grandparent [ ]  |
| Guardian / Other [ ]  | Step Parent [ ]  | Foster Carer [ ]  | ResidentKey Worker [ ]  |
| **Main Contact Name** |  |
| Parental Responsibility | Yes [ ]  | No [ ]  |
| Relationship to above |  |
| Address (if different) |  |
| Tel Number (if different) |  |
| Email (if different) |  |
| Preferred way(s) of communication  | Phone [ ]  | Email [ ]  | Post [ ]  | Other [ ]  |
| **Name** |  |
| Parental Responsibility | Yes [ ]  | No [ ]  |
| Relationship to above |  |
| Address (if different) |  |
| Tel Number (if different) |  |
| Email (if different) |  |
| Preferred way(s) of communication | Phone [ ]  | Email [ ]  | Post [ ]  | Other [ ]  |
|  |  |
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**Does the child / young person / family need any adjustments
in order to access the service**

|  |  |  |
| --- | --- | --- |
| Any access needs due to disability or health? *e.g. Learning disability, communication, developmental, physical or medical needs* | Yes [ ]  | No [ ]  |
| Please specify |  |

**GP Details**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Postcode |  |
| Telephone |  |
| Email |  |

**Nursery / School / College details**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Postcode |  |
| Telephone |  |
| Email |  |
| Contact name |  |  |
|  |  |
|  |  |  |
|  |  |
| Education, Health, Care Plan (EHCP) | Yes [ ]  | No [ ]  |
| If **YES** please give details (and attach plan): |  |
|  |  |  |
|  |  |  |
|  |  |
|  |  |  |
|  |  |

**Do any of the following apply to the child / young person**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Early Help Assessment | Yes - currently [ ]  | Previously [ ]  | No [ ]  |  |
| Team Around the Family Meetings | Yes - currently [ ]  | Previously [ ]  | No [ ]  |  |
| Adopted | Yes - currently [ ]  | Previously [ ]  | No [ ]  |  |
| Registered as a looked after child | Yes - currently [ ]  | Previously [ ]  | No [ ]  | Don’t know [ ]  |
| Identified as a Child in Need | Yes - currently [ ]  | Previously [ ]  | No [ ]  |  |
| Child Protection Plan | Yes - currently [ ]  | Previously [ ]  | No [ ]  |  |
| Any safeguarding concerns | Yes - currently [ ]  | Previously [ ]  | No [ ]  |  |
| Legal proceedings | Yes - currently [ ]  | Previously [ ]  | No [ ]  |  |
| Legal order(s) | Yes - currently [ ]  | Previously [ ]  | No [ ]  |  |
| Hospital | Yes - currently [ ]  | Previously [ ]  | No [ ]  |  |
| If answering **YES**, please provide details and attach any relevant reports: |  |

**Consent**

|  |  |  |
| --- | --- | --- |
| Has the child / young person consented to this referral | Yes [ ]  | No [ ]  |
| Has the parent / carer with parental responsibility consented to this referral | Yes [ ]  | No [ ]  |
| If no, please provide details why not*Please note: We can only process a request for help when we have consent from the person(s) with parental responsibility if child is under 16 years* | Yes [ ]  | No [ ]  |

**Referred by**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Email Address |  |
| Job Title  |  |
| **Date of Referral** |  |
| **Signed** |  |

**PART 2 Referral for Nursing Intervention**

**Ensure you also complete PART 1**

|  |
| --- |
| **What clinical nursing intervention does the child/young person require support with?** |
|  |
| **Does the child/young person require any equipment to support their clinical nursing need?** |
|  |
| **If there a specific date that the care needs to be delivered?*(Please supply copies of any care plans, treatment protocols or patient information provided)*** |
|  |
| **How long is the clinical intervention expected to be needed for?** |
|  |
| **What training have care givers received in order to support CYP needs*(Please supply copy of any competencies that have been completed)?*** |
|  |
| **Is there any plan for follow up by the referring centre or clinician?** |
|  |
| **If there is no specific clinical intervention identified what do you need the Community Children’s Nursing Team to support with?** |
|  |

Once completed please send this form to our **Single Point of Access**

**preferably by email:** cfhd.devonspa@nhs.net

**OR** alternatively by post:

Children and Family Health Devon, Single Point of Access Team,

1a Capital Court, Bittern Road, Sowton Industrial Estate, Exeter, EX2 7FW

Telephone 0330 024 5321

**PART 3 Child Blood Test Referral (non-urgent tests only)**

**Ensure you also complete PART 1**

**The community Children’s Nursing service do not provide routine blood tests, referrals of this type need to be completed within primary care or be referred to the hospital setting. The Community Children’s Nursing Service only accepts referrals for specialist blood tests for our current caseload or for children with additional needs.**

|  |
| --- |
| **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 a sample and if so what challenges were encountered?** |
| **Is specific date required** (e.g. 6 weeks post initiation of treatment)? |

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

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