Zoë's Place Baby Hospice Referral Form

Please complete as fully as possible and fill in boxes clearly. If a section is not appropriate for the child you are referring please state N/A within that section. For clarity the term child relates to all those referred between the ages of 0-6 years.

DETAILS OF THE CHILD BEING REFERRED

Hospice of choice: Coventry ☐ Liverpool ☐ Middlesbrough ☐		
Is this family new to the services of Zoë's Place Baby Hospice? Yes/No **Is this a re-referral to Zoë's Place Baby Hospice? Yes/No**		
Child's names:	**Family name (write N/A if not applicable)**	**NHS number:**
Child's gender: Male/Female	**D.O.B.**	
Contact via: letter/face to face/telephone		
Home address:		
Parent/carer email:		
Home Telephone:	**Mobile No:**	
Area/Local authority:		

DIAGNOSIS	ICD 10 CODE
1)	
2)	
3)	

Full medical background and current treatment (please attach any relevant medical summaries):

Are either of the following in-place for this child?	**YES***	**NO**
Emergency Care Plan/Advance Care Plan *Please attach a copy		
Symptom guidelines		

RELIGION AND ETHNIC ORIGIN

RELIGION: Baha'i: ☐ Buddhist: ☐ Christian: ☐ Prefer not to state religion ☐ Hindu: ☐ Jain ☐ Jewish: ☐ Muslim: ☐ No Religion ☐ Other Religion ☐ Pagan ☐ Sikh: ☐ Zoroastrian ☐

ETHNIC ORIGIN:

Asian or Asian British: Bangladeshi	☐	Mixed: Other Mixed	☐
Asian or Asian British: Indian	☐	Mixed: White and Asian	☐
Asian or Asian British: Other Asian	☐	Mixed: White and Black African	☐
Asian or Asian British: Pakistani	☐	Mixed: White and Black Caribbean	☐
Black or Black British: African	☐	Other Ethnic Group	☐
Black or Black British: Caribbean	☐	White: British	☐
Black or Black British: Other Black	☐	White: Irish	☐
Other Ethnic Groups : Chinese	☐	White: Any other White	☐
		Not Stated	☐

FIRST LANGUAGE: **Interpreter required?** **Yes / No**

FAMILY MEMBERS

CARER 1: Relationship to child	**Name**
Parental responsibility: Yes / No	
Email address:	
Date of birth of parent/carer:	
Mobile telephone no:	**Living with child: Yes / No**
CARER 2: Relationship to child	**Name**
Parental Responsibility: Yes / No	
Email address:	
Date of birth of parent/carer:	
Mobile telephone no:	**Living with child: Yes / No**
Are you happy to be contacted via email? Yes/No	
Can everyone receive correspondence? Yes/No	

SIBLINGS

Name & Surname (if different)	Gender	Relationship to child being referred	D.O.B (required)	Affected by same or other condition	Date of death

PROFESSIONAL INVOLVEMENT

PROFESSIONAL DESIGNATION	MAIN KEY WORKER (PLEASE TICK ONE ONLY)	MAIN ORGANISATION (PLEASE TICK ONE ONLY)	NAME/PRACTICE / HOSPITAL ADDRESS	CONTACT TELEPHONE NUMBER & E-MAIL
General practitioner				
Hospital paediatrician				
Community paediatrician				
Community nurse				
Health visitor				
Social worker				
Physio/OT				
Speech and language				
Dietitian				

All professionals must be added – please continue on a separate sheet if necessary and attach.

CCG:	

REFERRER'S DETAILS

DATE OF REFERRAL:

Name:	**Designation:**
Address:	**Telephone number:** **Email address:**

Has the parent / legal guardian agreed to this referral? Yes / No

PLEASE ENSURE THAT THE CONSENT FORM IS COMPLETED AND SIGNED BY PARENT

WHAT SUPPORT WOULD THE FAMILY LIKE FROM ZOË'S PLACE?

ALLERGIES

Allergies:	Allergy level e.g. intolerance / allergy / life-threatening

CURRENT TREATMENTS / MEDICATIONS

MEDICATION	DOSE & ROUTE	FREQUENCY
1)		
2)		
3)		
4)		
5)		
6)		

CURRENT CARE PACKAGE

Social Care	
Name of social worker	
Telephone number	
Care package hours daytime	
Short break nights	
Venue of short break nights	
Is the family able to access all of this package?	
Continuing healthcare funding	
Name of contact	
Telephone number	
Hours of nursing care provided - daytime	
Hours of nursing care provided - nights	
Are you able to access all of this package?	
Personal budget	
Are you currently accessing a personal budget?	
Education Health and Care Plan	**Please attach a copy if the child has one**

CURRENT FAMILY SITUATION

Details of other children's hospice referred to:	
Details of other children's hospice currently used and level of service offered	

IS THE CHILD SUBJECT TO ANY OF THE FOLLOWING?

	YES	NO
Current / previous safeguarding concerns		
Domestic abuse within the family home		
Significant mental health issues in either parent / carer		
Interim care order		
Full care order		
Residence order		

Details of above

REFERRER'S SIGNATURE: _____

PLEASE RETURN TO: Head of Care, Zoë's Place Baby Hospice:

Middlesbrough
High Street, Normanby
Middlesbrough
TS6 9DA
Tel: 01642 457985

Liverpool
Yew Tree Lane
Liverpool
L12 9HH
Tel: 0151 2280353

Coventry
Easter Way, Ash Green
Coventry
CV7 9JG
Tel: 02476 361675

Please ensure that the Consent Form below is signed by parents/carers as we will not be able to process a referral until the Consent Form is signed

CONSENT FORM - USING YOUR PERSONAL INFORMATION

Child's name: _____

Date of birth: _____ NHS number: _____

How information about you will be used

Zoë's Place Baby Hospice may request or share your personal information with other agencies and professionals including your GP, consultant paediatricians(s) and other professionals involved in the care of your child to assist us and those agencies/professionals to support you or your child and family. This could be related to all aspects of you or your child's or family's wellbeing, development, safety, behaviour, physical/mental health, social care, education, training, employment or housing. This could include social and healthcare funding.

It may affect the service that we offer you if you do not give us permission to share information.

If you are happy for us to share personal information as above, please sign below.

I give Zoë's Place Baby Hospice permission to share my personal information with other agencies to enable Zoë's Place and these agencies to support me, my child and family.

Name (please print):_____

Signature: **Date:**

Please let us know how you would prefer us to contact you with information about service provision to your child and family (e.g. bookings, letters etc): **Email ☐** **Post ☐**

Other contact from Zoë's Place:

Please let us know how you would prefer to receive general information from Zoë's Place Baby Hospice (e.g. invitations, newsletter): **Email ☐** **Post ☐** **Do not contact me ☐**

Email address (please print): …….

By providing your email address(es) you are giving us permission to contact you in this way.

We would also like to be able to contact you by text message to inform you about late notice availability of tickets or booking for our fundraising events. Please provide you mobile number if you are happy for us to do this:

Mobile 'phone number): ……..

By providing your mobile number(s) you are giving us permission to contact you via text about the above.

Name (please print):_____

Signature: **Date:**

Zoë's Place Baby Hospice abides by the Caldicott principles for information sharing (National Data Guardian 2020). If you would like further information, please contact the Head of Care:

Coventry: gina.harris@zoes-place.org.uk **Liverpool**: michelle.wright@zoes-place.org.uk

Middlesbrough: beth.hill@zoes-place.org.uk