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**Zoe’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 (see also section 1.3 in the Referral, admission, transition and discharge policy).

# **DETAILS OF THE CHILD BEING REFERRED**

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospice of choice: Coventry 🞏 Middlesbrough 🞏** | | | |
| **Is this family new to the services of Zoe’s Place Baby Hospice? Yes/No**  **Is this a re-referral to Zoe’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** | |  |  | |  |  | |  |  |   **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** | |

# **PARENTS/CARERS – disability support**

|  |
| --- |
| **Do you consider yourself to have a disability (including neuro-diverse issues e.g. dyslexia, ADHD, autism)? Yes/No**  If **Yes**, please state the type of impairment(s) which applies to you:  **Do you require any reasonable adjustments to be made/support provided (e.g. help with reading) if your child accesses care from Zoe’s Place? Yes/No**  If **Yes**, please describe the adjustments to be made and how you think we can support you. |

### **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 ZOE’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, Zoe’s Place Baby Hospice:**

**High Street, Normanby**

**Middlesbrough**

**TS6 9DA**

**Tel: 01642 457985**

**Head of Care, Zoe’s Place Baby Hospice:**

**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**

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Description automatically generated**Consent Form - using your personal information**

**Child’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NHS number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **How information about you will be used**  Zoe’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 Zoe’s Place Baby Hospice permission to share my personal information with other agencies to enable Zoe’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 Zoe’s Place:**

|  |
| --- |
| Please let us know how you would prefer to receive general information from Zoe’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:** |

**Zoe’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**: tracey.armstrong@zoes-place.org.uk **Middlesbrough**: beth.ogara@zoes-place.org.uk