

ZOE'S PLACE BABY HOSPICE: END OF LIFE/POST-DEATH 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 **N.B. ALL INFORMATION TO BE FILLED OUT IN FULL**

To avoid delay, please contact the appropriate hospice by telephone before sending through the Referral Form

Is this referral for end of life support:		Yes/No
Is this referral for post-death care:		Yes/No
Is this family new to the services of Zoe's Place Baby Hospice:		Yes/No
Surname:	Forename(s):	NHS No:
Gender: male/female/not known	D.O.B.	or expected date of delivery if not born yet:
Home address:		
Parent/carer email:		
Home telephone:	Mobile number:	
Area/Local Authority:	CCG:	

HOSPICE OF CHOICE COVENTRY ☐

MIDDLESBROUGH ☐

CIRCUMSTANCES (NATURE OF ILLNESS/LOSS) *Continue on separate sheet, if necessary

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PLEASE SPECIFY WHETHER AN IN-REACH VISIT IS TO TAKE PLACE OR IF A VISIT TO THE HOSPICE IS PREFERRED

Please state family preference:	In-reach visit by one of our staff at child's place of care	☐
	Family to visit the hospice	☐
	None of the above	☐

RELIGION AND ETHNIC ORIGIN

RELIGION:		
Baha'i: ☐ Buddhist: ☐ Christian: ☐ Hindu: ☐ Jain: ☐ Jewish: ☐ Muslim: ☐ Pagan: ☐ Sikh: ☐ Zoroastrian: ☐ Other religion: ☐ No religion: ☐ Prefer not to state religion: ☐		
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	DOB
Gender: male/female		Parental responsibility: Yes / No
Mobile telephone no:		Living with child: Yes / No
Address if different:		
CARER 2: Relationship to child	Name	DOB
Gender: male/female		Parental responsibility: Yes / No
Mobile telephone no:		Living with child: Yes / No
Address if different:		
Can everyone receive correspondence? Yes / No		

SIBLINGS

Name & surname (if different)	Gender	Relationship to child being referred	DOB (required)	Affected by same or other condition	Date of death

***Continue on separate sheet, if necessary**

PROFESSIONAL INVOLVEMENT

PROFESSIONAL DESIGNATION	NAME AND ADDRESS OF THE PRACTICE / HOSPITAL	TELEPHONE NUMBER	EMAIL ADDRESS
Palliative care consultant			
Hospital paediatrician			
Community paediatrician			
General practitioner			
Community nurse			
Health visitor/ midwife/school nurse			
Social worker			
Physio / O.T.			
Speech & language			
Dietician			

ALL PROFESSIONALS MUST BE ADDED – continue on separate sheet if necessary and attach

Is there an ACP in place which has been discussed with the family: Yes ☐ NO ☐ N/A ☐

If Yes, please provide a copy with referral

REFERRER'S DETAILS

DATE OF REFERRAL: _____

NAME:	DESIGNATION:
ADDRESS:	TELEPHONE NUMBER & EMAIL ADDRESS:

Has the person with parental responsibility agreed to this referral? Yes / No

CURRENT MEDICATIONS

MEDICATION	DOSE & ROUTE	FREQUENCY
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		

If the referral is for post-death care, please provide the name and contact of chosen funeral directors, if known:

CURRENT FAMILY SITUATION

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REFERRER'S SIGNATURE: _____

PLEASE ENSURE THAT THE CONSENT FORM BELOW IS SIGNED BY PARENTS/CARERS - we will not be able to process a referral until the Consent Form is signed.

CONSENT FORM - USING YOUR PERSONAL INFORMATION

Child's name:

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Date of birth:

NHS number:

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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.

Please note that we may ask parents/carers to temporarily register with the Zoe's Place GP service.

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:

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