

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

1)	
2)	
3)	

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

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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:	
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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?

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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

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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 'Consent Form for using your personal information' is signed by parents/carers as we will not be able to process a referral until this 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

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 your 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