Children’s Community Nursing Referral Form

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| **Area** | **Telephone** | **Working Hours** | **E-mail referral to:** |
| Child Must be registered with a GP in the London Borough of Bromley | **0300 330 5777**  Please phone to check referral was received and accepted | Mon-Fri 08.00-18.00 | [**Bromh.CCCpod5refs@nhs.net**](mailto:Bromh.CCCpod5refs@nhs.net)  **And**  **Bromh.ccntnurses@nhs.net** |

**Completion Guidance:**

* Where referrals are expected to be carried out the following day CCNT must receive completed referral form by 15.00
* Please ensure relevant sections of referral form are completed in full, incomplete referrals will not be accepted and will delay discharge.

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| **First Name:** | | **Surname:** | **D.O.B.:**    **Sex: Male/Female** |
| **Address:**  **Post Code:** | | **NHS Number:**  **Religion:** | **Ethnic origin:**  **Language:**  **Interpreter required: Yes/No** |
| **Parent/carer name & mobile:** | | **Parent/carer name & mobile:** | **Parent/carer email:** |
| **GP Details:** | | | |
| **Diagnosis:**  **Allergies:** | **Reason for referral:** *Please also complete relevant sections**of this form*  **Date first visit required:**  **Date of review at hospital:** | | |
| **Safeguarding in relation to the child / Risks to staff:** | | | |
| **Consent:** *All families must be aware of the referral to the community nursing team*  **Have family consented to the referral:** Yes / No | | | |

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| 1. **Medication / Central Line:** *Please ensure the drug chart, medication and relevant diluents are prescribed correctly and supplied with the patient, in addition the prescription including diluents needs to be emailed with this referral form.*  ***Please ensure the family have an emergency line care pack on discharge.*** | | | | | | | | | | | |
| Drug name and Brand: | | | Dose: | | | | Frequency: | | Patient weight (Kg): | | |
| Route :  Oral □  Intramuscular □  Subcutaneous □ Insuflon □  Peripheral cannula □  Midline / Long line □  Central line □    Port / Hickman / PICC  Date of insertion: \_ \_ / \_ \_ / \_ \_ | Does the IV access require a dressing change: Yes / No  Frequency:  Dressing details:  Next due: \_ \_ / \_ \_ / \_ \_ | | | | | When is first dose required by CCNT? (Date & time)  \_ \_ / \_ \_ / \_ \_ \_ \_ \_:\_ \_  When is last dose required by CCNT?  \_ \_ / \_ \_ / \_ \_ | | | | Flush used:  0.9% Sodium chloride □  Other □ Please specify | |
| 1. **Enteral:** *Please attach feed plan for all enterally fed children* | | | | | | | | | | | |
| **PEG:** | **Gastrostomy Button:** | | | | | **Gastrojejunostomy:** | | **Nasogastric/ Nasojejunal tubes:** | | | |
| Type**:**  Freka □  Medicina □  Corflo □  Other:  Size:  Length:  1st Rotation date: \_\_/\_ \_/\_ \_  1st Advancement date:\_ \_/\_ \_/\_ \_ | Type and size**:**  Mic-key button □  Mini button □  Water for the balloon: (ml)  Date of next water change:  \_ \_ / \_ \_ / \_ \_ \_ \_  Date of next button change:  \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | Type:  Mic Jej □  G-Jej □  Peg-JeJ □  Other:  Size: | | Size and length:  Type:  NEX Measurement:  Insertion date:  \_ \_ / \_ \_ / \_ \_ \_ \_  Change next due:  \_ \_ / \_ \_ / \_ \_ \_ \_ | | | |
| 1. **Wound Care:** *Please give 14 days’ supply of products used* | | | | | | | | | | | |
| Description, size & site of wound: | | | | Dressing details & frequency of changes | | | | Date of last dressing change:  \_ \_ / \_ \_ / \_ \_ \_ \_  Date of next dressing change:  \_ \_ / \_ \_ / \_ \_ \_ \_ | | | |
| 1. **Respiratory:** | | | | | | | | | | | |
| Oxygen requirement:  (L/min):  - Continuous / Nocturnal  -Weaning / On-going  Method of administration: (Please delete)  - Face Mask / Nasal Cannula  - Neonatal/ Paediatric / Adult | | **Asthma Referrals:** *Please tick the reason for the referral**& attach patient’s asthma management plan*  □ Two or more previous attendances/ admissions with wheeze/asthma in the last 12 months  □ Previous severe exacerbation requiring IV treatment  □ Concerns with inhaler technique or general management and understanding of condition  □ Any other concern (specify):  **Child’s peak flow**:  Advised to see the GP within 48-72 hours? Y/N | | | | | | | | | Tracheostomy: Y/N  Size and type:  Ventilation: Y/N  CPAP: Y/N BiPAP: Y/N  Pressures:  NPA: Y/N  Size: |
| 1. **Stoma/ Continence:** | | | | | | | | | | | |
| □ ACE □ Cecostomy □ Colostomy □ Duodenostomy □ Ileostomy  □ Urinary catheter □ Urostomy □ Suprapubic Catheter  Size: Brand: Date of insertion/ formation: \_ \_ / \_ \_ / \_ \_ \_ \_  Continence assessment required □ | | | | | | | | | | | |
| 1. **Monitoring:** | | | | | | | | | | | |
| Saturation □ Blood Pressure □ Blood Level Monitoring□ Urinalysis □  Parameters: Frequency:  Contact details if monitoring falls outside of parameters: | | | | | | | | | | | |
| 1. **Continuing Care:** *Please attach recent social services assessments, clinical reports and EHCP* | | | | | | | | | | | |
| Brief description of child’s complex needs: | | | | | | | | | | | |
| 1. **Training**: *Please attach the most recent individualised care plan and prescription if relevant to the training* | | | | | | | | | | | |
| Who requires the training (delete as required): Parent/ Carer/ Respite/ School Staff/ Family Member  Contact details of trainee: Address: Telephone Number:  Please specify the training required: | | | | | | | | | | | |
| 1. **Haemoglobinopathy:** | | | | | | | | | | | |
| Diagnosis/haemoglobinopathy type: Last Sickle Cell Crisis: \_ \_/\_ \_/ \_ \_  Complications: Details: | | | | | | | | | | | |
| 1. **Diabetes:** | | | | | | | | | | | |
| Starter Pack Given □ Monitor Given □  Sharps Box □  Carbohydrate Counting Ratios: | | | | | Insulin Doses:  Breakfast: units Lunch: units  Dinner: units Pre-Bed: units | | | | | | |
| 1. **Palliative or Other:** | | | | | | | | | | | |
| Brief description of nursing need: | | | | | | | | | | | |

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| **Key Professionals Involved** | **Name** | **Contact Details** |
| Consultant |  |  |
| Social Worker |  |  |
| Clinical Nurse Specialist |  |  |
| Other |  |  |

**Please give 14 days’ supply of all equipment and stock required**

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| **Referrer’s Name** |  |
| **Designation** |  |
| **Date** |  |
| **Telephone Number** |  |
| **E-mail Address** |  |
| **Please call to confirm receipt of referral and capacity to accept** | |

**Please note that you do not need to complete every section of the form – just the section relevant to the referral that you are making. Not all team provide services for all the referral sections.**

**This referral form can be used for the following teams:**

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| **Area covered** | **Team Email** |
| **Bexley and Greenwich** | Send Email [oxl-tr.CCNTeam@nhs.net](mailto:oxl-tr.CCNTeam@nhs.net) |
| **Bromley** | [Bromh.cccpod5refs@nhs.net](mailto:Bromh.cccpod5refs@nhs.net) / [bromh.ccntnurses@nhs.net](mailto:bromh.ccntnurses@nhs.net) |
| **City and Hackney** | [huh-tr.hackneyccnt@nhs.net](mailto:huh-tr.hackneyccnt@nhs.net) |
| **Croydon** | [mhn-tr.chah@nhs.net](mailto:mhn-tr.chah@nhs.net) |
| **Harrow** | [LNWH-tr.harrowccn@nhs.net](mailto:LNWH-tr.harrowccn@nhs.net) |
| **Hillingdon** | [cnw-tr.CommunityChildrensNursingTeam@nhs.net](mailto:cnw-tr.CommunityChildrensNursingTeam@nhs.net) |
| **Islington** | [Why-the.islingtonchildrensnursing@nhs.net](mailto:Why-the.islingtonchildrensnursing@nhs.net) |
| **Kensington & Chelsea; Hammersmith & Fulham; Westminster** | [CLCHT.CCNTeam@nhs.net](mailto:CLCHT.CCNTeam@nhs.net) |
| **Newham** | [elt-tr.CCNSNewham@nhs.net](mailto:elt-tr.CCNSNewham@nhs.net) |
| **Southwark and Lambeth (Evelina)** | [gst-tr.evelinalondonccnteam@nhs.net](mailto:gst-tr.evelinalondonccnteam@nhs.net) |