

**Children’s Community Nursing Team – Referral Form**

**All requested information MUST be completed otherwise referral will be rejected.**

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| **Name:** | **NHS:** |
| **DOB:** | **Gender:** | **Ethnicity/ Religion:** |
| **Address (inc Postcode):** | **Telephone Contacts:** |
| **Legal Responsibility:** | **Name of Alternative Carer and Address:** |
| **GP:** | **Health Visitor/ School Nurse:** |
|  |
| **Social Work Involvement: Y/N****Social Worker Name:****Reason for Involvement:****Child Protection/Child In Need/TAF?****Any Other Concerns?** |
|  |
| **Reason for Referral & Nursing Intervention Required:** |
| **Specific Parameters:**  | **Respiratory Rate:**  |
| **Heart Rate:** | **Oxygen Saturations:**  |
| **Blood Pressure:** | **Weight:** |
| **Equipment sent home with Patient: Children must be sent home with one week’s supply of required equipment as CCNT do not have stock of items. These are ordered in on patient specific basis.**  |
| **Medication List:**  |
| **Significant Past Medical History:** |
| **When to seek further advice or return to hospital?** |
| **Specific Concerns?** |
| **Any Other Professional Involvement?****Consultants:****Specialists:****Dietician:** **SALT:****Physiotherapist:** **OT:** |
| **Source of Referral (Name & Telephone Number):**  |
| **Date of Referral: Date of Visit:**  |
| **Discharge Planning Meeting:** |
| **Consultant Responsible for Care:** |

**Please contact the team to discuss all referrals prior to sending. Thank you.**

**Contact Details: 0191 2834660 or 07790934372
Referrals to be sent to:** **ghnt.referrals-gatesheadccnt@nhs.net**

Gateshead Borough