

**Child Health Service referral form**

**Children’s community nursing**

\*Required field

|  |
| --- |
| **For referrals to be accepted the following is required**    All referrals need to come from Healthcare professionals.    If you are a parent/carer and think your child should be referred to the Children's Community Nursing Team please discuss this with doctors or nurses at the hospital where your child is being treated or your GP |

# General information

|  |  |  |  |
| --- | --- | --- | --- |
| \*Date of referral |  | \*Childs date of birth |  |
| \*Childs first name |  | \*Childs family or last  name |  |
| \*Name child likes to  be known by |  | NHS Number (if known) |  |
| \*Name of parent/carer/guardian with parental responsibility | |  | |
| \*Email of parent/carer for appointments, reports and information to be sent | |  | |
| \*Address where the child lives | |  | |
| \*Contact number for parent /carer | |  | |
| Name of second parent that has legal responsibility (if different from above) | |  | |
| What is your relationship to parent listed above | |  | |
| Address of second parent/carer if different to listed above | |  | |
| Contact number of second parent/carer | |  | |

Medway Community Healthcare CIC providing services on behalf of the NHS

Registered office: MCH House, Bailey Drive, Gillingham, Kent ME8 0PZTel: 01634 337593

Registered in England and Wales, Company number: 07275637

**Who else works with the family or child?**

|  |  |
| --- | --- |
| \*GPs name and address |  |
| Hospital doctors name and address |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Service | | Service | |
|  | Speech and language therapy |  | Physiotherapy |
|  | Occupational therapy |  | Dieticians |
|  | Podiatry |  | Learning disability nurses |
|  | Social worker |  | Community nurses |
|  | Health Visitor |  | School nurse |
|  | Child and adolescent wellbeing service (NELFT) |  | Special needs nursery |
|  | Audiology |  | Ophthalmologist |
| Other – please state: | |  | |

**For schools and nurseries**

|  |  |
| --- | --- |
| \*Name and address of nursery or school |  |
| \*Contact person name and email address |  |
| \*Contact number |  |

**Safeguarding**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Yes | No |
| \*Does the child have a child protectio | n plan? |  |  |
| \*Is the child a child in need? |  |  |  |
| \*Is the child a looked after child? |  |  |  |
| \*Has early help been initiated? |  |  |  |
| Any further information |  | |  |
| Social workers name and contact details |  | |  |

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## Consent

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| \*Are the parents/carers in agreement to this referral? |  |  |

|  |  |
| --- | --- |
| \*Referrers name |  |
| \*Email address |  |
| Hospital trust, ward and ward phone number |  |
| Local hospital named consultant |  |
| Referring Centre named Consultant |  |

**Children’s Nursing Specific Referral Question.**

|  |  |
| --- | --- |
| Diagnosis |  |
| Allergies |  |
| Current medication |  |
| Reason for referral |  |
| Is there a protocol for treatment? If so please attached to email |  |
| Follow up and discharge plan |  |
| Equipment/devices/supplies  Please provide specifics |  |
| If the child is required to have observations please provide normal range | |
| Heart rate |  |
| Respiratory rate |  |
| Blood pressure |  |

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