ZOËS PLACE
BABY HOSPICE

ZOË'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 young person you are referring, then 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 Zoë'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:		
Carer Email:		
Home Telephone:		**Mobile No:**
Area/Local Authority:	**CCG:**	

HOSPICE OF CHOICE **COVENTRY** ☐ **LIVERPOOL** ☐ **MIDDLESBROUGH** ☐

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

PLEASE SPECIFIY WHETHER AN IN REACH VISIT IS TO TAKE PLACE OR IF A HOSPICE VISIT 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:** ☐ **Declines Religion** ☐ **Hindu:** ☐ **Jain** ☐ **Jewish:** ☐ **Muslim:** ☐ **No Religion** ☐ **Other Religion** ☐ **Pagan** ☐ **Sikh:** ☐ **Roman Catholic** ☐

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 child	**Name**
Gender: Male/Female	**Parental Responsibility: Yes / No**
Mobile Telephone No:	**Living with child: Yes / No**
Address if different:	
CARER 2: Relationship child	**Name**
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	D.O.B (required)	Affected by same or other condition	Date of Death

*Continue on separate sheet, if necessary

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
PALLIATIVE CARE CONSULTANT				
HOSPITAL PAEDIATRICIAN				
COMMUNITY PAEDIATRICIAN				
GENERAL PRACTITIONER				
COMMUNITY NURSE				
HEALTH VISITOR				
SOCIAL WORKER				
PHYSIO / O.T.				
SPEEECH & LANGUAUGE				
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 parent / legal guardian agreed to this referral? Yes / No

CURRENT MEDICATIONS

MEDICATION	DOSE & ROUTE	FREQUENCY
1)		
2)		
3)		
4)		
5)		

If referral for Post Death Care, if known, please provide the name and contact of chosen Funeral Directors

CURRENT FAMILY SITUATION

REFERRER'S SIGNATURE: _____

PLEASE RETURN TO: **Referral Administration, Zoë's Place Baby Hospice, Yew Tree Lane, West Derby, Liverpool. L12 9HH.**

Tel: 0151 228 0353 **Fax:** **020151 252 2280**

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/YP Name: .....

Date of Birth: ..... NHS Number: .....

How information about you will be used

Zoë'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 your 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 Zoë's Place Baby Hospice permission to share personal information with other agencies to enable us and them to support you, your child and family.

Name: .....
(Please print)

Signature: Date:

Zoë's Place Baby Hospice abides by the Revised Caldicott principles (2013) for information sharing. If you would like further information, please contact gina.harris@zoes-place.org.uk