ZOËS PLACE
BABY HOSPICE

ZOË'S PLACE BABY HOSPICE COVENTRY, 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

Is this family new to the services of Zoë's Place Baby Hospice Yes/No Is this a re-referral to Zoë's Place Baby Hospice Yes/No		
Child Names:	Family Name; Not applicable	NHS No:
Gender: Male/Female	D.O.B.	
Contact via: SELF/LETTER/FACE TO FACE/TELEPHONE		
HOME ADDRESS:		
Carer Email:		
Home Telephone:		Mobile No:
Area/Local Authority:		

HOSPICE OF CHOICE

COVENTRY ☐

LIVERPOOL ☐

MIDDLESBROUGH ☐

DIAGNOSIS	ICD 10 CODE
1)	
2)	
3)	

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

Are either of the following in-place for this child?	YES*	NO
Emergency Care Plan/Advance Care Plan		
Symptom Guidelines		

*Please attach a copy

RELIGION AND ETHNIC ORIGIN

RELIGION:

Baha'i: ☐ **Buddhist:** ☐ **Christian:** ☐ **Declines 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 child	**Name**
Parental Responsibility: Yes / No	
Email Address:	
Mobile Telephone No:	**Living with child: Yes / No**
CARER 2: Relationship to child	**Name**
Parental Responsibility: Yes / No	
Email Address:	
Mobile Telephone No:	**Living with child: Yes / No**
Are you happy to be contacted via email: Yes / No	
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

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 / O.T.				
SPEEECH & LANGUAUGE				
DIETICIAN				

ALL PROFESSIONALS MUST BE ADDED – Continue on separate sheet if necessary and attach

CCG:	

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 THE CONSENT FORM ON PAGE 6 IS COMPLETED AND SIGNED BY PARENT

WHAT SUPPORT WOULD THE FAMILY LIKE FROM ZOE'S PLACE?

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 family able to access all this package?	

Continuing Healthcare Funding	
Name of contact	
Telephone Number	
Hours of nursing care provided - Day Time	
Hours of nursing care provided - Nights	
Are you able to access all 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

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: **Referral Administration, Zoë's Place Baby Hospice, Easter Way, Coventry. CV7 9JG**
Tel: **02476 361675** **Fax:** **02476 365540**

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: .....

Please let us know how you would prefer us to contact you

For information about service provision to your child and family; i.e. bookings, letters etc.

Email: ☐ Post: ☐

For general information from Zoë's Place Baby Hospice; i.e. invitations, newsletters

Email: ☐ Post: ☐ Do not contact me: ☐

By providing your email address(es) you are giving us permission to contact you in this way.

Email address(es) please print: .....

In addition, we would also like to be able to contact you by text to inform you about late notice booking availability or tickets for events that become available.

I am happy to be contacted by text in the future. By providing your mobile number(s) you are giving us permission to contact you in this way including via text.

Mobile phone number(s) .....

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