



## ZOË'S PLACE BABY HOSPICE MIDDLESBROUGH, REFERRAL FORM

Please complete as fully as possible. 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

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

DIAGNOSIS	ICD 10 CODE
1)	
2)	
3)	

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

--

<i>Are either of the following in-place for this child?</i>	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	<input type="checkbox"/>	Mixed: Other Mixed	<input type="checkbox"/>
Asian or Asian British: Indian	<input type="checkbox"/>	Mixed: White and Asian	<input type="checkbox"/>
Asian or Asian British: Other Asian	<input type="checkbox"/>	Mixed: White and Black African	<input type="checkbox"/>
Asian or Asian British: Pakistani	<input type="checkbox"/>	Mixed: White and Black Caribbean	<input type="checkbox"/>
Black or Black British: African	<input type="checkbox"/>	Other Ethnic Group	<input type="checkbox"/>
Black or Black British: Caribbean	<input type="checkbox"/>	White: British	<input type="checkbox"/>
Black or Black British: Other Black	<input type="checkbox"/>	White: Irish	<input type="checkbox"/>
Other Ethnic Groups : Chinese	<input type="checkbox"/>	White: Any other White	<input type="checkbox"/>
		Not Stated	<input type="checkbox"/>

### FIRST LANGUAGE:

Interpreter Required?

Yes / No

## FAMILY MEMBERS

<b>CARER 1: Relationship child</b>	<b>Name</b>
<b>Parental Responsibility: Yes / No</b>	
<b>Email Address:</b>	
<b>Mobile Telephone No:</b>	<b>Living with child: Yes / No</b>
<b>CARER 2: Relationship to child</b>	<b>Name</b>
<b>Parental Responsibility: Yes / No</b>	
<b>Email Address:</b>	
<b>Mobile Telephone No:</b>	<b>Living with child: Yes / No</b>

## 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 AND NAME	PRACTICE / HOSPITAL ADDRESS	CONTACT TELEPHONE NUMBER AND E-MAIL ADDRESS
<u>GENERAL PRACTITIONER</u>		
<u>HOSPITAL PAEDIATRICIAN</u>		
<u>COMMUNITY PAEDIATRICIAN</u>		
<u>COMMUNITY NURSE</u>		
<u>HEALTH VISITOR</u>		

<u>SOCIAL WORKER</u>		
<u>PHYSIO / O.T.</u>		
<u>SPEECH &amp; LANGUAGE</u>		
<u>DIETICIAN</u>		

<b>CCG:</b>	
-------------	--

## REFERRER'S DETAILS

**DATE OF REFERRAL:** \_\_\_\_\_

<b>NAME:</b>	<b>DESIGNATION:</b>
<b>ADDRESS:</b>	

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**

<b>Allergies:</b>	<b>Allergy Level</b> e.g. Intolerance / Allergy / Life Threatening

**CURRENT TREATMENTS / MEDICATIONS**

MEDICATION	DOSE & ROUTE	FREQUENCY
1)		
2)		
3)		
4)		
5)		
6)		

<b>Current Care Package</b>	
<b>Social Care</b>	
Name of Social Worker	
Telephone Number	
Care Package Hours daytime	
Short Break Nights	
Venue of Short Break Nights	
Is family able to access all of this package?	
<b>Continuing Healthcare Funding</b>	
Name of contact	
Telephone Number	
Hours of nursing care provided - Day Time	
Hours of nursing care provided - Nights	
Are you able to access all of this package?	
<b>Personal Budget</b>	
Are you currently accessing a personal budget?	
<b>Education Health and Care Plan</b>	<b>Please attach a copy if the child has one</b>

## CURRENT FAMILY SITUATION

--

<b>Details of other Children's Hospice referred to</b>	
<b>Details of other Children's Hospice currently used and level of service offered</b>	

Hospice of Choice (tick)                      Zoë's Place Baby Hospice                                           

### 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		

<b>Details of Above</b>
-------------------------

**REFERRER'S SIGNATURE:** \_\_\_\_\_

**PLEASE RETURN TO:** Referral Administration, Zoë's Place Baby Hospice, Crossbeck house, High Street, Normanby, Middlesbrough TS69DA. Tel: 01642457985 Fax:01642 440792

**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 [lisa.collins@zoes-place.org.uk](mailto:lisa.collins@zoes-place.org.uk)