Care Referral/Admissions Form

Brian House Children's Hospice

Please complete this referral form in full and return it to Brian House

Child/Young Persons details	
Surname:	First Name(s):
Child Like to be referred to as:	
Date of Birth:	Gender:
NHS Number:	Ethnic Group:
Home Address:	
Postcode:	Home telephone number:
Alternative telephone numbers (please include who's number this is):	
First Language:	Religion:
Nursery, School or College attended:	
Primary Diagnosis & Date Diagnosed:	

Primary Criteria (Please tick all that apply to the Child/Young Person named above) **All referrals will be reviewed on a case by case basis and decision to admit to hospice care undertaken by a multidisciplinary panel.**	
Are aged pre-birth to 15 years 364 days	
GP within our geographical area (FY1-8, PR3, PR4)	
Secondary Criteria (Please tick all that apply to the Child/Young Person named above)	
Does the child/young person have one of the following conditions:	
Criteria 1 – Life Threatening Condition **Curative Treatment may be feasible but can fail. Access to Palliative Care Services may be necessary when treatment fails or during an acute crisis.**	
Examples:	
• Cancer – Undergoing active treatment, poor prognosis, relapse, recurrence, bone marrow / stem cell transplant	
• Irreversible organ failure – Heart, Lung, Gut (requiring TPN)	
• Complex congenital Heart Disease	
• Transplant	
• Long term ventilation (excluding level 3)	
Criteria 2 – Conditions where premature death is inevitable **There may be periods of intense treatment aimed at prolonging life**	
Examples:	
• Cystic Fibrosis	
• Muscular Dystrophy	
• SMA Type 1	
Criteria 3 – Progressive Conditions without curative treatment **Treatment is palliative and may extend over many years**	
Examples:	
• Battens	
• Mucopolysaccharidosis	
• Severe Mitochondrial Disorder	
• Progressive neurological disorder	
Criteria 4 – Irreversible but non progressive conditions causing severe disability, leading to susceptibility to health complications / likelihood of premature death	
Examples:	

• **Severe Cerebral Palsy**	
• **Complex Health Conditions – complex / poorly controlled seizures, Severe scoliosis compromising respiratory function, Frequent medical interventions**	
• **Complex Disabilities**	
• **Potential of death**	
Criteria 5 – Referral for end of life care / use of Butterfly Suite	
If you have been unable to discuss the potential of death with the family please explain why	
Does the child have an Advanced Care Plan (please include)	
Have discussions taken place regarding resuscitation / emergency plans- please explain	

Parents details			
Carer 1: Parental responsibility? (Please tick):		Carer 2: Parental responsibility? (Please tick):	
Name:		Name:	
Date of Birth:		Date of Birth:	
Relationship to child:		Relationship to child:	
First Language:		First Language:	
Interpreter Required:		Interpreter Required:	
Address (if different from above)		Address (if different from above)	
Ethnic Group:		Ethnic Group:	

Siblings details			
1	Name:	Gender:	DOB:
	Health Needs:		
2	Name:	Gender:	DOB:
	Health Needs:		
3	Name:	Gender:	DOB:
	Health Needs:		
4	Name:	Gender:	DOB:
	Health Needs:		
5	Name:	Gender:	DOB:
	Health Needs:		
6	Name:	Gender:	DOB:
	Health Needs:		

Other family/friends regularly involved in caring for the child/young person			
	Name:	Relationship to child:	Contact number:
1			
2			
3			

Professional Involvement – Medical		
General Practitioner (GP):		
Practice Address:		
Post Code:	**Telephone:**	**Fax:**

Consultants involved in care			
Name:	**Speciality:**	**Telephone:**	**Hospital:**
1.			
2.			
3.			

4.			

Professional Involvement – Others **e.g. Health Visitor, School Nurse, Children's Community Nurse, Social Worker, Physiotherapist, SALT**		
Name:	Title/Role:	Telephone:
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Current family situation additional and supporting information

What help is the family looking for from Brian House Children's Hospice?

Have the child's parents (or those with parental responsibility consented to the referral?	**Yes**		**No**	
In order to process the referral, we will need to contact the professional(s) involved in caring for the child/ young person. Do you have consent from the child (where appropriate) or Parent/ Guardian for us to contact any professional you have provided details for on this form?	**Yes**		**No**	
Is the child subject to any Safeguarding Plans?	**Yes**		**No**	

Are there any known risks within the family's home environment: Please tick appropriate box:

• No known history of violence, alcohol, drug abuse within the home environment.	
• Current knowledge of violence, alcohol/drug abuse within the home environment.	
• Knowledge of previous violence, alcohol, drug abuse within the home environment.	

Provide details of any other providers providing support to the family not detailed above:

Any additional information you feel may be relevant:

Referrers details		
Name:		Relationship to Child:
Job Title:	Telephone:	Mobile:
Organisation:		
Email Address:		
Signature:		Date: