

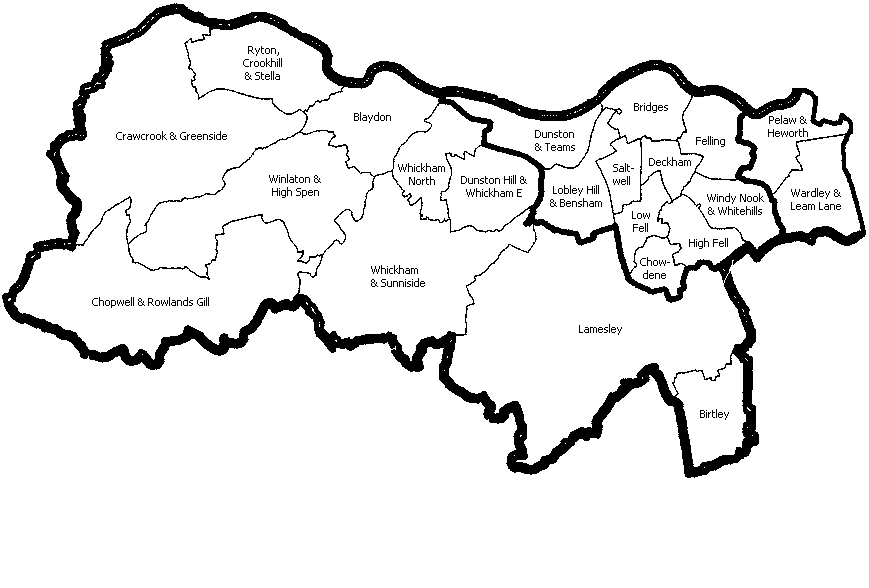
**Children’s Community Nursing Team – Referral Form**

**All requested information MUST be completed otherwise referral will be rejected.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | | **NHS:** | |
| **DOB:** | **Gender:** | | **Ethnicity/ Religion:** |
| **Address (inc Postcode):** | | **Telephone Contacts:** | |
| **Legal Responsibility:** | | **Name of Alternative Carer and Address:** | |
| **GP:** | | **Health Visitor/ School Nurse:** | |
|  | | | |
| **Social Work Involvement: Y/N**  **Social Worker Name:**  **Reason for Involvement:**  **Child Protection/Child In Need/TAF?**  **Any Other Concerns?** | | | |
|  | | | |
| **Reason for Referral & Nursing Intervention Required:** | | | |
| **Specific Parameters:** | | **Respiratory Rate:** | |
| **Heart Rate:** | | **Oxygen Saturations:** | |
| **Blood Pressure:** | | **Weight:** | |
| **Equipment sent home with Patient: Children must be sent home with one week’s supply of required equipment as CCNT do not have stock of items. These are ordered in on patient specific basis.** | | | |
| **Medication List:** | | | |
| **Significant Past Medical History:** | | | |
| **When to seek further advice or return to hospital?** | | | |
| **Specific Concerns?** | | | |
| **Any Other Professional Involvement?**  **Consultants:**  **Specialists:**  **Dietician:**  **SALT:**  **Physiotherapist:**  **OT:** | | | |
| **Source of Referral (Name & Telephone Number):** | | | |
| **Date of Referral: Date of Visit:** | | | |
| **Discharge Planning Meeting:** | | | |
| **Consultant Responsible for Care:** | | | |

**Please contact the team to discuss all referrals prior to sending. Thank you.**

**Contact Details: 0191 2834660 or 07790934372  
Referrals to be sent to:** [**gan-tr.gatesheadccnt@nhs.net**](mailto:gan-tr.gatesheadccnt@nhs.net)



Gateshead Borough