

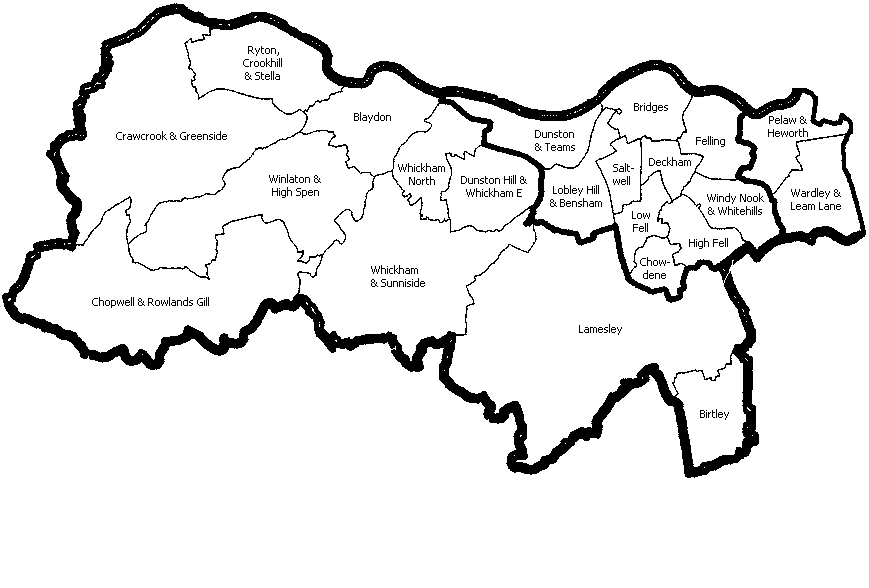
**Children’s Community Nursing Team – Newborn Blood Spot Referral Form**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | | **NHS:** | |
| **DOB:** | **Gender:** | | **Ethnicity/ Religion:** |
| **Address (inc Postcode):** | | **Telephone Contacts:** | |
| **Legal Responsibility - Names and Contact Details:**  **Mother’s Name:**  **Mother’s DOB:**  **Mother’s NHS:** | | **Name of Alternative Carer and Address:** | |
| **GP:** | | **Health Visitor/ School Nurse:** | |
|  | | | |
| **Social Work Involvement: Y/N**  **Social Worker Name:** | | | |
|  | | | |
| **Reason for Referral & Nursing Intervention Required:** | | | |
| **Date Child Health Notified:** | | **Consent Obtained for Newborn Bloodspot:** | |
| **Interpreter Required:** | | **Newborn Bloodspot Card Provided to Family:** | |
| **Source of Referral (Name & Telephone Number):** | | | |
| **Date of Referral: Date of Visit:** | | | |

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

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



Gateshead Borough