

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

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

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| **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:** **gan-tr.gatesheadccnt@nhs.net**

Gateshead Borough