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care@richardhouse.org.uk

RICHARD HOUSE REFERRAL FORM

CHILD'S DETAILS

First Name Surname

Date of birth Male Female

Address Post code

NHS number

FAMILY DETAILS

Mother's name Home telephone

Occupation Mobile phone

Address (please state 'as above' if same as child) Email address

Post code

Father's name Home telephone

Occupation Mobile phone

Address (please state 'as above' if same as child) Email address

Post code

1. Name	Date of birth	M	F
2. Name	Date of birth	M	F
3. Name	Date of birth	M	F
4. Name	Date of birth	M	F
Significant others	Their relationship to child		

REFERRER'S DETAILS

Name of referrer: Job title:

Address: Post code:

REFERRER'S DETAILS (continued)

Telephone

Email or fax

Signed

Date

Reason for referral

Known allergies (please list in full):

Diagnosis

Past medical history

Main care issues

Are there any safeguarding or psychosocial issues?

Does this child receive a funded package of care? Y/N If yes, how many hours _____

Have parents consented to referral? Y N
(Please ensure that the consent form has been completed and signed as referral cannot be processed until this has been done.)

Professional sought verbal consent Y N Signed Date

Is the child aware of hospice referral? Y N

Is the child known to Great Ormond Street Palliative Care Team: Y N

Is the child currently using the services of another hospice? Y N

THE FOLLOWING MUST BE SIGNED BY THE PERSON WITH PARENTAL RESPONSIBILITY

I, _____ (full name) _____ (relationship to young person) hereby consent to the child named above being referred to Richard House support services by the person named on this form. I understand that Richard House will contact me to perform an initial assessment.

I also give Richard House permission as part of the initial assessment to make contact with other professionals, as required, to gather information.

Signed _____ Date _____

IMPORTANT

For this referral to proceed, Richard House Children's Hospice require current medical consultant clinic letter or hospital discharge summary. Please include letters with the referral.

Name of Nursery/School

Address _____ Postcode _____
Phone number _____

School Nurse

Address _____ Postcode _____
Phone number _____

Letter/Report attached? Y N

GP

Address _____ Postcode _____
Phone number _____

Letter/Report attached? Y N Fax number _____

Paediatrician

Address _____ Postcode _____
Phone number _____

Letter/Report attached? Y N Fax number _____

Specialist Consultant

Address

Postcode

Phone number

Letter/Report attached?

Y

N

Fax number

Community Children's Nurse

Address

Postcode

Phone number

Letter/Report attached?

Y

N

Fax number

Health Visitor

Address

Postcode

Phone number

Letter/Report attached?

Y

N

Fax number

Social worker

Address

Postcode

Phone number

Letter/Report attached?

Fax number

ETHNIC BACKGROUND (please tick as appropriate)

WHITE	ASIAN/ ASIAN BRITISH	BLACK/ AFRICAN/ CARIBBEAN/ BLACK BRITISH
English Welsh / Scottish / Northern Irish / British Irish	Indian	African
Irish	Pakistani	Caribbean
Gypsy or Irish Traveller	Chinese	Other (Please state)
Other (please state)	Other (Please state)	
MIXED	OTHER ETHNIC GROUPS	
White & Black Caribbean	Arab	
White & Black African	Other (Please state)	
White & Asian		
Other (Please state)		
Main language spoken		
Is an interpreter needed?	Y	N

RELIGION

Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	Muslim
Buddhist	Sikh
Hindu	No religion
Jewish	Other religion (please specify)

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