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| **Details of Child /Young Person** |
| NHS no: | Date of Completion: | Date of Review: |
| Name: | DOB:  |
| Permanent Address:Tel No:Email: | Current Address: (if applicable)Tel No:Email: |
| Who else lives at the permanent Address? | Are there any safe guarding concerns? |
| Ethnicity:  | First Language: | Translator needed: |
| Parent/Carers Relationship:Address:Tel No: | Parent/Carers Relationship:Address:Tel No: |
| GP:Practice: Tel No: | CCG. |
| PR = Parental responsibility |  |
| Education Placement: | School | 2 years, 15 hours | Nursery | College | Other |

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**PERSONAL INFORMATION**

**Professional/Service Contact Sheet**

Please provide ALL ACCURATE CONTACT DETAILS AND REPORTS

| **Professional /Service involved** | **Contact Number** | **Address** | **Email** | **Involvement of Care** | **Report attached** |
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**Referral Form**

(this form is to be used in conjunction with details of Young Person sheet and Professional/Service Contact sheet and Consent Form)

**Referrer Details (Person completing this form)**

Name:

Profession:

Address:

Tel No Email:

Signature: Date

**Diagnosis/Needs**

**Diagnosis/Needs**

**What are the unmet healthcare needs?**

**Relevant Medical History**

(please include any hospital admissions in the last 12 months)

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**Social Care History**

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**If the young person is 16+ please give details of the level of consent the young person is able to give.**

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**Medication Sheet**

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| **Name of Medication** | **Dose** | **Frequency** |
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**Specialist Equipment**

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| --- | --- |
| **Type of Equipment needed** | **Frequency of Use** |
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**Is there an Advanced Care Plan in place ? YES / NO**

**What support services are already in place?**

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| **Name of Service** | **Hours of Provision** | **Funded by?** |
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**Evidence of Multi-Agency Working including Common Assessment Framework (CAF) if applicable**

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| --- | --- | --- |
|  | **Yes** | **No** |
| Is there a CAF in place? |  |  |
| Is there are EHC in place? |  |  |
| In progress? |  |  |

Please send your completed Referral Form to:

Children’s Continuing Care Team

Riverside House

2nd Floor

Goldcrest Way

Newburn Riverside

Newcastle upon Tyne

NE15 8NY

Tel. No. 0191 2236551

Email: NECSU.CHTadmin@nhs.net

**CONSENT FORM**

For the Child health team to complete an assessment, the consent form needs to be completed by the family and returned with the referral form.

**Permission to Share Information**

The Information recorded during this document may be shared with others involved in your child’s care. This may be used for consideration of your child’s eligibility for NHS

Continuing care

|  |  |  |
| --- | --- | --- |
| Do you give your consent for information of yourself/your child recorded in this document to be shared with others involved in care? | **Yes** | **No** |
| Is there any specific information about yourself/your child you would NOT wish to be shared? *(Please give details below)***Information NOT to be shared :** | **Yes** | **No** |
| Are there any agencies or individuals with whom you would NOT wish information about yourself/your child to be shared? *(please give details below)***Information NOT to be shared with :** | **Yes** | **No** |
| Service User/Patient unable to give consent *(please give details below)*Capacity Assessment attached if no capacity to consent. | **Yes** | **No** |
| **Yes** | **No** |
| Signature of Service User/Patient or their Representative | Date: |
| In accordance with the Mental Capacity Act (2005), it is deemed that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert name) has the capacity to consent as above. (Aged 16 years and over).  |
| **Name:** |
| **Relationship:** |