

Evelina @Home Children’s Community Nursing Referral Form

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| **Area** | **Telephone Mon - Fri** | **Working Hrs** | **E- mail referral to** |
| Lambeth and Southwark | 020 3049 7585 | 08.00 -18.00 | **gst-tr.evelinalondonccnteam@nhs.net** |

# Date of referral: Planned discharge date

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| **First Name:**   | **Surname:**  | **D.O.B: Sex:**  **Weight:**  |
| **Address:**   **Postcode: NHS Number:**  |
| **Parent/Carer** **Mobile No:**  | **Parent/Carer Parent/Carer Email:****Mobile No:**  |
| **Continuing Care Assessment Required:**  | **Language:**  |

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| **Key Professionals Involved****Designation** | **Name** | **Contact Details** |
| **Consultant** |  |  |
| Social Worker |  |  |
| CNS |  |  |
| Allied Professionals |  |  |
| Health Visitor/School Nurse |  |  |
| Other |  |  |
| **GP Name and Address:** | **Any Safeguarding Concerns:** |

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| **Diagnosis and Relevant Previous History** |
| **Treatment on this Admission** |
| **Reason for Referral:**  **First Visit required on:** **PLEASE EMAIL DRUG CHART WITH REFERRAL FORM FOR ALL MEDICATIONS** |
| **Any Additional Details:** |
| **Monitoring Referrals: What are the Parameters?** |
| **Blood Pressure:**.**SAO2:** **Other:**  |
| **Respiratory Referrals: PPLOG Discharge Bundle Commenced?** |
| Oxygen requirement: Method of administration:Nasal cannula:  | Tracheostomy Y/NVentilated Y/N |
| ***IVAB and injection administration referrals: At least 24 hours’ notice required*** |
| Drug name:  | Dose (mg): | Frequency: |
| When is the first dose required?Date: \_\_\_ / \_\_\_ / \_\_\_Time: ­­ \_\_ : \_\_ | Date of last dose:\_\_\_ / \_\_\_ / \_\_\_Time: \_\_:\_\_ | Tick to confirm complete TTA has been dispensed. *This includes: drug chart, drug, diluent, flushes.* ☐ |
| *Access? Peripheral Central (indicate type)* |
| ***Wound care referrals:*** |
| Description of wound: | Dressing details: | Frequency of changes: | Tick to confirm supplies for 3 dressing changes have been given. ☐ |
| Last changed:\_\_\_ / \_\_\_ / \_\_\_ |

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| ***Nasogastric tube referrals: Has Risk Assessment been completed if o/n feed?*** |
| ***Tube size and length*** | ***Date of insertion:*** | ***Length inserted to:***  | ***Date of next tube change*** |
|  ***\_\_\_\_\_\_Fr \_\_\_\_\_\_cm*** | \_\_\_ / \_\_\_ / \_\_\_\_ | cm  | \_\_\_ / \_\_\_ / \_\_\_\_ |
| Tick to confirm 14 days (minimum) of supplies have been given including spare NG tube and tapes ☐ |
| ***Gastrostomy referrals:*** | ***Gastrojejunostomy referrals:*** | ***Buttons* *referrals:*** | ***Freka referrals:*** |
| *Please tick appropriate box:* * Mic-Key (Button)
* Mi-Ni (Button)
* PEG (Freka)
* Medicina
* Other (*please specify)*

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Size: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | *Please tick appropriate box:* * Mic-Jej (Button)
* G-Jej (Button)
* Peg-J (Freka)
* Other (*please specify)*

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Size:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of insertion: \_\_\_ / \_\_\_ / \_\_\_ | Date of insertion: \_\_\_ / \_\_\_ / \_\_\_ |
| Date of next water change (weekly):\_\_\_ / \_\_\_ / \_\_\_ | Date of first rotation:\_\_\_ / \_\_\_ / \_\_\_ |
| Date of first advance:\_\_\_ / \_\_\_ / \_\_\_ |
| Tick to confirm 14 days (minimum) of supplies have been given including spare button if relevant ☐ |

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| **Referred by:**  | **Designation:**  | **Tel No:**  |
| **Ward:**  | **Hospital:**  |

**ETHNICITY MONITORING**

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| **Ethnicity** |  |  |  |  |  |
| **White**  |  | **Asian** |  | **Other Ethnic Groups** |  |
| British |  | Indian |  | Chinese |  |
| Irish |  | Pakistani |  | Any other group |  |
| Any other white background |  | Bangladeshi |  | Not stated |  |
|  |  | Any other Asian background |  |  |  |
| **Mixed** |  |  |  |  |  |
| White and Black Carribean |  | **Black or Black British** |  |  |  |
| White and Black African |  | Carribean |  |  |  |
| White and Asian |  | African |  |  |  |
| Any other mixed background |  | Any other black background |  |  |  |