**Children’s Community Nursing (CCN) Referral Form**

This form must be only completed by a health care professional. Please complete and return to the email address at the end of the form.

Please DO NOT discharge the patient from your service until CCN team have accepted referral

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| **Name:** Male/Female  | **Date of birth:**  |
| **NHS number:** **MRN:** | **Named consultant:**  |
| **Parent or carer’s name:** **Relationship to the child:** | **Home address:****Postcode:** |
| **Contact details for parent/carer****Landline:****Mobile:****Email:** | **GP:****Contact number:** |
| **Heath visitor:****Contact number:** | **Social worker:****Contact number:** |
| **Main language:****Is an interpreter required? Yes/ No** | **Faith group:****Ethnic origin:** |
| **Medication:** | **Allergies/intolerances:** |
| **Reason for referral:****Estimated date for discharge:** | **Medical history/ known conditions:** **Does the CYP have a Learning Disability? Y/N** |
| **Baseline observations:**HR………………………B/P……………………….RR……………………….Sats……………………… | **Breathing and circulation:**Oxygen requirement: Y/NLitres/min:Cylinders: Concentrator:Face mask: Y/N (type and size):Nasal cannula: Y/NSuction: Y/N Catheter/Yankauer size: |
| **Last Resus Training (date):**  | **HOOF** | **Y/N** |
| **Oxygen pathway completed**  | **Y/N** |
| **Nutrition: Referral to dietician: Y/N N/A**  |
| Breast:  | Y/N | Type and frequency of feed/feeding plan (mls/kg):Abbott E-reg completed  | Y/N |
| Bottle:  | Y/N |
| Gastrostomy:  | Y/N |
| Naso-gastric: If Y please state size of NG: | Y/N |
| Jejunostomy:  | Y/N |
| Parenteral feeding: | Y/N |
| **Parental competencies:**Please list any competencies obtained/outstanding:Competencies attached with referral: Y/N To be sent: |
| **Wound care Specific: Nature of Wound:****Wound care required:****Type of dressings/current care plan:****Referral to Tissue Viability Y/N N/A** |
| **Skin/Wound:**Significant marks:If yes please note:Birthmark/blue/grey spot | Y/NY/N | **Equipment/Dressings: (Including IVAB ancillaries)** |
| **Is there any safeguarding concerns or safeguarding history?****Are there any risks to visiting the child’s home?** | **Source of Referral (ward, consultant, other professional):****Contact Number:****Name of referring person:****Signature of referring person:****Date:**  |

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| **Please return this referral form by secure email to the appropriate address below which are suitable for sending sensitive and confidential information securely.**For Berkshire West: ccnwest@berkshire.nhs.ukFor Berkshire East: ccneast@berkshire.nhs.uk **Please Note the criteria for CCN East:** child/young person has a learning disability coupled with complex health/nursing need.  |