**Children’s Community Nursing West Referral Form**

**Part 1**

This form must be completed by a health care professional. Please complete and send the form 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.**

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| **Name:** Male/Female  | **D.o.B:**  |
| **NHS number:**  | **Named Consultant:**  |
| **Parent or Carer’s name:** **Relationship to the child:** | **Home address:****Postcode:** |
| **Contact numbers for parents/carers** **Landline:****Mobile:****Email:** | **GP:****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:**  |
| **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 / N |
|  | **Last Resus Training (date):**  | **HOOF Y/N****Oxygen pathway completed Y/N** |
| **Nutrition : Referral to Dietician: Y/N N/A**Breast: Y / N Bottle: Y / NNaso- Gastric: Y / N (If Y please state size of NG): Size: **Can NG tube be repassed in the home Y/N**Gastrostomy: Y / NJejunostomy: Y / NParenteral feeding: Y / NType and frequency of feed/feeding plan (mls/kg):Abbott E-Reg completed: 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 Podiatry if below ankle Y/N**  |
| **Skin/Wound:**Significant marks Y / NIf Y please note:Mongolian Blue spot: Y / N | **Equipment/Dressings:** **(ordered supplied)** |
| **Are 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 email address below:**childrenscommunitynursingwest@berkshire.nhs.uk |

**Incomplete referrals will be returned**

**Children’s Community Nursing Referral/discharge Form**

**Part 2**

Please keep CCN team informed when patient is discharged home.

On discharge, please ensure the following has been completed and this form emailed to the CCN Team: childrenscommunitynursingwest@berkshire.nhs.uk

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| **DISCHARGE CHECK LIST** | **YES** | **NO** | **N/A** |
| **CCN referral form completed, emailed & accepted: named CCN: ……………………** |  |  |  |
| **TTOS (including Milk feeds, hepsal/saline & dressings)** |  |  |  |
| **Plastics (NG tube, giving sets, syringes etc at least one week supply)** |  |  |  |
| **Copy of parent competencies for CCN** |  |  |  |
| **Pink BHFT Prescription Chart for CCN** |  |  |  |
| **Open Access Letter to RBH/ED** |  |  |  |
| **Equipment ordered/supplied** |  |  |  |
| **Additional: please list** |  |  |  |

**Referral Reference Guide**

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| --- | --- |
| **Nursing Need** | **Additional** |
| **Naso Gastric feeds** | 1. Referral to inpatient dietician
2. Parent/carer NG competencies (copy for CCN)
3. Abbott e-reg set up (dieticians will assist/advice)
4. If applicable Abbott pump training: 0800 0183799
5. At least 1 week supply of plastics, milk etc from Ward
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| **Oxygen dependant**  | 1. Please commence Home Oxygen pathway: RBH intranet
2. Ward to arrange HOOF, Risk Assessment & oxygen home delivery (Dolby website: www.dolbyvivisol.com .

 **Need at least 24 hours notice unless emergency.** 1. BLS training for parents/carers
2. Oxygen competencies to be completed (copy for CCN)
3. Oxygen escalation plan if required
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| **Equipment**  | If the patient requires equipment at home please contact CCN ASAP to help arrange. NB: Equipment can take several weeks to set up. |
| **Short/Long term IVAB** | 1. Make contact with CCN ASAP so we can assist with home set up. **Need at least 24 hours notice**
2. IVAB infusions can only be administered via a central access device in the community
3. Liaise with inpatient pharmacy to assist with home care delivery and prescriptions.
4. Complete CCN prescription form
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| **Wound dressings** | 1. Clear instructions on referral form
2. Adequate supply of dressings (at least one week)
3. Contact details of named Consultant and medical/surgical team patient is under.
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