**Children’s Community Nursing Referral Form**

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

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| Child’s Name:Preferred name: | NHS number:MRN: |
| Diagnosis/Reason for referral: |
| Gender: M/ F | Date of birth: |
| AddressPost code: | Do they have any allergies? Please specify. |
| Do they require any medication? Please specify. |
| Telephone number:Mobile number: | Main language:Is an interpreter required? Y / N |
| Communication preference:Phone / Email | Faith group:Ethnic origin: |
| GP name:Telephone number:Secure email: | Parent or carer’s name:Relationship to the child:Address:Telephone:Email: |
| Consultant name:Telephone number:Secure email: |
| Social worker name:Telephone number:Secure email: | Next of kin name (if different to the above):Relationship to the child:Address:Telephone:Email: |
| School nurse/Health visitor:Telephone:Secure email: |
| Are there any known safeguarding concerns?Are there any risks to visiting professionals?If yes, please provide more information | Source of referral (Consultant, ward, other professional etc):Secure email address:Contact number:Signature of referring person:Date: |
| **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 GPs: ccnwest@berkshire.nhs.uk For Berkshire East GPs: ccneast@berkshire.nhs.uk |
| ***For CCN use only***Date referral received:Date visit booked: |

**The referral will be accepted and if declined the referrer will be notified within 5 working days.**