**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: |
| Address  Post 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](mailto:ccnwest@berkshire.nhs.uk)  For Berkshire East GPs: [ccneast@berkshire.nhs.uk](mailto: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.**