**Leeds Children’s Community Nursing Team Referral Form**

Please email completed forms to **community.childrensnursing@nhs.net**

Mon-Fri: 0113 276 1294 Weekends/Bank holidays: 07950755273

|  |  |  |
| --- | --- | --- |
| **Discharge date** | **Discharging ward** | **Date 1st visit required** |
| **Surname** | **First Name** | **Preferred Name** |
| **NHS no** | **DOB** | **Gender** |
| **Allergy status** | **Weight** | **Language** |
| **Patient Religion/Belief** | **Ethnicity** | **Interpreter needed?** |
| **1.Parent/Carer Name** | **2.Parent/Carer Name** |
| **Relationship****Parental responsibility?** | **Relationship****Parental responsibility?** |
| **Address** | **Address** |
| **Postcode** | **Postcode** |
| **Contact Number** | **Contact Number** |
| **GP Name****GP Telephone no** | **GP Address****Postcode** |
| **Diagnosis** |
| **Reason for referral** |
| **Competencies met by parents/carers** |

|  |  |  |
| --- | --- | --- |
| **Name** | **NHS No** | **DOB** |

**MEDICATION:**

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| --- | --- | --- | --- |
| **Medication**  | **Dose** | **Route** | **Frequency** |
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**DRESSINGS/EQUIPMENT**: Please supply ONE FULL WEEKS worth, while these are ordered from the GP.

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| --- | --- | --- |
| **Product** | **Size** | **Quantity** |
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**PROFESSIONALS INVOLVED:**

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| --- | --- | --- | --- |
| **Profession** | **Name** | **Base** | **Contact No** |
| Speciality Consultant |  |  |  |
| Speciality Nurse |  |  |  |
| Health Visitor/School Nurse |  |  |  |
| Dietician |  |  |  |
| SALT |  |  |  |
| Physiotherapist |  |  |  |
| Social Worker |  |  |  |
|  |  |  |  |

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| **SAFEGUARDING** Child Protection/Safeguarding concerns identified?Action taken:Any family history of: [ ]Domestic violence [ ]Substance misuse [ ]Parental ill health [ ]Social care involvementChild protection plan? |

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| --- | --- | --- |
| **Date referred** | **Name of Referrer** | **Contact details**  |