AD Number:

Referral Form

Alexander Devine Children's Hospice Service

Child's details

First name		Surname	
Known as		Date of birth	
Gender		Religion	
NHS number		Tel number	
Email			
Address			
Postcode			

Ethnic groups

White

English / Welsh/ Scottish/ Northern Irish / British Irish ☐
Gypsy or Irish Traveller ☐
Any other white background* ☐

Mixed / Multiple Ethnic Groups

White and Black Caribbean ☐
White and Black African ☐
White and Asian ☐
Any other mixed / multiple ethnic background* ☐

Asian / Asian British

Indian ☐
Pakistani ☐
Bangladeshi ☐
Chinese ☐
Any other Asian background ☐

Black / African / Caribbean / Black British

African ☐
Caribbean ☐
Any other Black / African / Caribbean background* ☐

Other Ethnic Groups

Arab ☐
Any other ethnic group* ☐

*Please specify if using these categories _____

Diagnosis and likely prognosis:

Discussions held with parents/guardians/young person regarding diagnosis, prognosis and service:

Yes ☐ No ☐

Brief Medical History: Please provide a summary of clinical care over the last 12 months including changes in symptoms and any interventions

Have the family engaged in Advance Care Plan conversations? Yes ☐ No ☐

Does child/young peron have an Advance Care Plan in place? Yes ☐ No ☐

Family details

Next of kin 1 name		Next of kin 2 name	
Relationship to child		Relationship to child	
Marital status		Marital status	
Address		Address	
Postcode		Postcode	
Tel number		Tel number	
Main language		Main language	
Interpreter required		Interpreter required	
Ethnic group		Ethnic group	
Religion		Religion	
Legal guardian / parental carer responsibility (if not parents) Name and address: Tel number:			

Siblings

Name	Gender	Date of birth

Details of any child protection / child in need plan

Referrer

Name		Email	
Role		Date	
Tel number		Signature	

Permission from Parent / Guardian / Young person

☐ Please tick to confirm that verbal consent has been obtained from parent, guardian or young person

Permission must be obtained to process the referral

Professionals involved with child / young person

General practitioner

Name		Telephone	
Address		Email	

Consultants

Consultant name	Hospital	Tel number	Email

Community team

Team	Address	Tel number	Email

Other (Health visitor / Social worker / Physio / Dietician

Name	Job role	Address	Tel number	Email

School / Nursery

Name	Address	Tel number

Details of any other charities or organisations the child is involved with

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For admin use

AD reference number:

ICD 10 code: _____

ACT category: _____

Spectrum of Colours at referral

Alexander Devine Children's Hospice Service
Reg. Charity No 1118947
Reaching out to every child and family that needs us
www.alexanderdevine.org
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