AD number:

TCD number:

Referral Form

Please note that referrals cannot be processed without the essential information marked with *

Child's details

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

***Diagnosis and likely prognosis:**

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

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 person have an Advance Care Plan in place Yes ☐ No ☐

*Referrer (Health Care Professional / Parent / Guardian)

Name		**Relationship to Child**	
Email		**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 prior to making a referral

*Ethnic group (of child / young person)

White		**Asian / Asian British**		**Black / African / Caribbean / Black British**	
White: British	☐	Indian	☐	Black or Black British: African	☐
White: Irish	☐	Pakistani	☐	Black or Black British: Caribbean	☐
White: Any Other White	☐	Bangladeshi	☐	Black or Black British: Other Black	☐
		Chinese	☐		
		Other Asian	☐		
Mixed / Multiple Ethnic Groups					
Mixed: White and Asian	☐	Mixed: White and Black Caribbean	☐		
Mixed: White and Black African	☐	Mixed: Other Mixed	☐	**Other:** _____	☐

*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	Same address?

Details of any child protection / child in need plan

***Are there any reasons why a home visit by a lone worker should not be undertaken?**

Yes ☐ No ☐

Professionals involved with child / young person

*General practitioner

Name		Telephone	
Address		Email	

*Consultants (Please give the details of at least one consultant involved in the child's care)

Consultant name	Hospital	Tel number	Email

Community team

Team	Address	Tel number	Email

Support Package in Place (Continuing health / social / private)

Team	Hrs of Care p/week	Tel number	Email

Other (e.g. 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 involved with the child/young person/family

Any further information?

Please send completed form via email to referrals@alexanderdevine.org

For Alexander Devine Children's Hospice Service use:

Source of referral: _____

Reason for referral: EOL care / Respite / Symptom management / Post bereavement care inc Dolphin Suite

Date referral received: _____

Date referral processed (letters sent): _____

Date taken to clinical committee: _____

Accept ☐ / Decline ☐ /Seek further information ☐

ICD 10 code: _____

ACT category: _____

Spectrum of Colours at Acceptance:

Snowball Hill
Maidenhead
Berkshire
SL6 3LU
T: 01628 822777
E: referrals@alexanderdevine.org

Alexander Devine Children's Hospice Service is the operating name of Alexander Devine Children's Cancer Trust.
Company No: 5757493. Registered Charity No: 1118947

www.alexanderdevine.org