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

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

Mon-Fri: 0113 276 1294

Weekends/Bank holidays: 07950755273

Service Hours: 8.30am-5pm **Monday to Friday**

8.30am – 4.30pm **Weekends and Bank Holidays**

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| **Referrer Details** | |  | |  |
| **Date of Referral:** | **Name of Referring Service:** | | **Referrer Name and Profession:** | |
| **Date 1st visit required:**  **Time First Visit Required (CIVAS/ANTIBIOTIC PATIENTS ONLY):** | **Hospital Discharging ward:**  **Hospital Discharge date:** | | **Address:**  **Contact Number:** | |
| **Consent** | | I have gained the appropriate informed consent of either the parent/carer or the child/young person (required for referral acceptance) | | |
| **Patient Details** | |  | |  |
| **Surname** | | **First Name** | | **Preferred Name** |
| **NHS no** | | **DOB** | | **Sex** |
| **GP Name**  **GP Telephone no** | | **GP Address**  **Postcode** | | **Language** |
| **Patient Religion/Belief** | | **Ethnicity** | | **Interpreter needed?** |

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| **Safeguarding** |  | |  |
| **Are there any safeguarding or significant social concerns *(Please note, staff work alone, this information therefore maybe essential for staff safety)***  **Yes  No**  **If yes, please give detail:** | | **Is there any social care involvement?**  **Yes**  **No** | |
| **Parent/Carer Details** | |  | |
| **1.Parent/Carer Name** | | **2.Parent/Carer Name** | |
| **Relationship**  **Parental responsibility?** | | **Relationship**  **Parental responsibility?** | |
| **Address** | | **Address** | |
| **Postcode** | | **Postcode** | |
| **Contact Number** | | **Contact Number** | |
| **Referral Details** | | | |
| **Diagnosis:** | | | |
| **Reason for referral:** | | | |
| **Training/teaching needs for parents/carers:** | | | |

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| **MEDICATION** |

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| **Allergy status:** | **Weight:** |

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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.  **CIVAS Patients:** Please provide dressings packs, syringes, needles, sharps bins and antibiotics for the course duration |

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| **Product** | **Size** | **Quantity** |
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