

Richard House Children's Hospice Referral Proforma

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| NHS No. |
| Child's RH Index No. |

Details of client (child/young adult) being referred:

Child's First Name:

Child's Surname:

Gender (Please tick): Male Female

Date of Birth:

Mother/Carer's Full Name:

Father/Carer's Full Name:

Sibling(s):
(including Names & Ages)

Address:
Postcode:

Parents/Carers living at same address? Y N

Telephone No 1:

Telephone No 2:

Family's 1st Language:

Parental Consent For referral obtained? Yes No

Health Advocate Req'd? Yes No

Ethnicity:

GP's Name:

Practice Name & Address:

Address cont -

Practice Tel No:

Name of Tertiary Centre Hospital Telephone No:

Name of Lead Consultant Telephone No:

Name of Local Hospital Telephone No:

Name of Paediatrician Telephone No:

Community Paediatrician Telephone No:

Details of Referral:

Name of Referrer:

Referrer's Job Title:

From (Service):

Referrer's Tel No:

Date of Referral:

Service Required:

Outreach Family Support Young Adults Group

Day Care Residential Family Support

Religious Denomination:

To be completed by Richard House Staff:

Lead responsible:

Allocated Team:

Date of 1st Panel:

Date Parents Informed:

Date Medical Info Required:

Fits Criteria Yes No

Genetic-Other Metabolic Neuro - Acquired

Neuro - Congenital Organ failure -acquired

Organ failure- Congenital Undiagnosed

Category (Please tick): 1 2 3 4

Case Status & Date:

Active Deferred

Date of 1st Review:

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Parental Consent

Please confirm that parental consent has been given for Richard House to contact professionals listed below, Yes No
should written information be required.

Other professionals: Please complete as fully as possible.

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|---|--|--------------------------------------|-----------------------------------|
| Social Services Occupational Therapist | Name/Job Title: | Health Occupational Therapist | Name/Job Title: |
| | Name & Address of Organisation | | Name & Address of Organisation |
| | Tel No: Fax: | | Tel No: Fax: |
| | Email: | | Email: |
| Physiotherapist | Name/Job Title: | | |
| | Name & Address of Organisation: | | |
| | Telephone: | Fax: | Email: |
| Speech & Language Therapist | Name/Job Title: | | |
| | Name & Address of Organisation: | | |
| | Telephone Number: | Fax: | Email: |
| Social Worker | Does this child have a Social Worker, If so, please list : | | |
| | Name/Job Title: | | |
| | Name & Address of Organisation: | | |
| | Telephone Number: | Fax: | Email: |
| Nursery/School | Does this child you are referring attend nursery or school? If so please list: - | | |
| | Name & Address of nursery/school: | | |
| | Name of Nursery Nurse / School Nurse: | | |
| | Telephone Number: | Fax Number: | Email: |
| Others | <i>Such as Dietician, Psychologists</i> | | |
| | Name/Job Title: | | |
| | Name & Address of Organisation: | | |
| | Telephone Number: | Fax: | Email: |
| Others | <i>Such as Dietician, Psychologists</i> | | |
| | Name/Job Title: | | |
| | Name & Address of Organisation: | | |
| | Telephone Number: | Fax: | Email: |

