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| **Children and Young People’s Continuing Care** **End of Life Referral Form** |
| **PART ONE: TO BE COMPLETED BY REFERRER.** |
| **End of Life Criterion** |
| The child or young person named in this referral fulfils the criteria where end of life care is deemed appropriate and written supportive evidence outlining the presenting needs and short life expectancy has been documented by a Consultant. This form should only be used when the current commissioned services like local hospices or hospice at home services are unable to meet the health needs of the child or young person.  |
| **Child or Young Person’s Details** |
| Name: |  |
| Date of birth: |  | NHS Number: |  |
| Address: |  |
| Current Location: |  |
| Date of Discharge: (if applicable) |  |
| Discharge Location (if applicable) |  |
| Gender: (delete as appropriate) | MALE / FEMALE |
| Mother’s name: |  | Father’s name |  |
| Contact no: |  | Contact no: |  |
| NB. Details of one parent only are acceptable, but it must be the parent with responsibility. |
| **If Parental Responsibility Is Not Held By Parents**  |
| Parental responsibility held by: |  | Contact no: |  |  |
| Email: |  |  |
| Basis of parental responsibility: (e.g legal guardian, LA section 20 etc.) |  | Address: |  |  |
| **Brief Description of Illness/Condition: (Diagnosis, Reason for Fast Track)** |
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| **What Support/Services Has the Child or Young Person and/or Family/Carer Requested?** |
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| **Is there a “Wishes Document” in Place? If so please summarise** |
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| **Care Package Required:**  |
| In receipt of existing continuing care package? If yes, with who? |  |
| In receipt of existing social care package or care? |  |
| Proposed package of care: |  |
| Any Equipment Required: |  |
| Proposed Cost of Package: | £ |
| **Health Professionals Involved** |
| **Service** | **Name/Address and Telephone Number** |
| Registered General Practitioner (GP) |  |
| Social Worker |  |
| Community Paediatrician  |  |
| Palliative Care Team |  |
| Hospice/s involved |  |
| Other  |  |
| **Referrer Details** |
| Name of Referrer |  |  |
| Signature |  |  |
| Date |  |  |  |
| The referral form must be fully completed sent to the Children’s Complex Care Team at: BNSSG CCG

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| **E-Mail**: bnssg.cc.childrens@nhs.net **Tel**: 0117 984 1656 |

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| **PART TWO: TO BE COMPLETED BY CCG COMPLEX CARE TEAM NURSE ASSESSOR.** |
| Name of Nurse Assessor |  |
| Date of Triage |  |
| Decision | Agree/Disagree |
| Recommendation/s  |  |
| Rationale |  |
| Nurse Assessor Signature  |  |
| Countersigned by CYP Complex Care Manager or Associate Director Quality (CHC) or another Associate Director | Signature |  |
| Name |  |
| Package to be reviewed in 1 2 3 4 5 6 weeks/months |
| **Children’s Continuing Care Panel** |
| Date Ratified at Panel |  |

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| **PART THREE: FUNDING AUTHORISATION – TO BE COMPLETED BY CCG.** |
| Total Amount Funding Agreed: | £ |
| Breakdown of Costs: |  |
| Speciality - Is the CCG fully or Joint funding the package (Delete as appropriate)? | FullyJoint |
| What type of PHB (Circle/highlight as appropriate)? | NotionalThird PartyDirect Payment |
| Funding description for QA? | End of Life Care |
| Invoice to: |  |
| Start Date: |  |