Great Ormond Street Hospital for Children NHS Foundation Trust

REFERRAL REQUEST FORM

for Paediatric Palliative Care Team Services
at Great Ormond Street Hospital for Children NHS Foundation Trust

Date:		GOS / NHS No:	

PATIENT DETAILS					
Name:		DOB:		Gender:	M / F
Address:		Tel:			
		Mobile:			
		Ethnicity:			
		Religion:			

REFERRER DETAILS		GP DETAILS	
Name:		Name:	
Designation:		Practice:	
Consultant Lead:		Address:	
Address:			
Tel:		Tel:	
Fax:		Fax:	

CLINICAL INFORMATION

Diagnosis and date of diagnosis:

Is the patient ventilated? Y / N (if Y please add details in current problems / treatment boxes below)

Current problems:	Current treatment:

Current psychosocial needs:

Why would you like palliative care involvement:

(please provide details)

(please tick appropriately)

Medical / nursing ☐

Psychosocial ☐

Is the patient known to any other GOS team?	Y / N
If yes, which:	

Is the patient known to any other psychosocial team (GOS or external)?	Y / N
If yes, which:	

Is the patient known to any local services?	Y / N
If yes, which: (please include contact details)	

FAMILY / CARER INFORMATION			
Mum's name:		Siblings:	Ages:
Dad's name:			
Other carers:			

Are parents aware of referral?	Y / N
Family spoken language:	
Family / Social history:	
Any other relevant information:	

Please send completed referral form to the Paediatric Palliative Care Team by fax to 020 7829 7983

FOR OFFICIAL USE ONLY:			
Date received:		Added to database:	
Consultant:		PCT area:	