



Demelza
Hospice Care for Children

Demelza Referral Form

Child details

Name: _____ Date of Birth: _____ NHS No: _____

Tick as applicable Male Female Unknown

Address: _____		Telephone: _____ Mobile: _____ Other Contact: _____ Email: _____
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Please specify if you have a contact preference:
If you provide a telephone number and an email address, you are consenting to us contacting you by either of these methods for the purposes of your referral and future service provision with Demelza.

In order to ensure that we offer the best possible response, we may contact parents/carers/young people following the outcome of a referral. Please advise if you are happy to be contacted for feedback.
 Yes No

Where did you hear about Demelza:

Ethnicity: _____ First Language: _____ Other Languages: _____ Interpreter Required: YES / NO		Religion: _____ Nationality: _____ Immigration Status: _____
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Diagnosis:

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Is this child subject to any of the following: (please tick appropriate box)

Child in Need Plan Child Protection Plan Child in Care: By Voluntary Agreement or,
Under an Interim Care Order Full Care Order Emergency Protection Order

Please provide further details: (including any risks you think we need to be aware of and any contact restrictions)

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Parent(s) / Carer(s) details:

Birth Parents: (please provide full contact details for both parents if different to the child's)

Mother's Name: Address: Date of Birth: Parental responsibility <input type="checkbox"/>	Telephone: Mobile: Other Contact: Email:
Father's Name: Address: Date of Birth: Parental responsibility <input type="checkbox"/>	Telephone: Mobile: Other Contact: Email:

Primary Carer(s): (if the child is not looked after by their birth parents, please provide details of the child's primary carer(s), including full contact details if different to the child's)

Name: Relationship to child: Address: Date of Birth: Parental responsibility <input type="checkbox"/>	Telephone: Mobile: Other Contact: Email:
Name: Relationship to child: Address: Date of Birth: Parental responsibility <input type="checkbox"/>	Telephone: Mobile: Other Contact: Email:

Siblings details:

Name	Date of Birth	Male / Female / Unknown

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Additional information about this referral: (e.g. current family / home situation, including any identified risks)

Services Working with Child:

Professional's Name:	Address:	Telephone / Fax Number
GP		
Consultant		
Community Consultant		
Social Worker / Local Authority		
Community Children's Nurse		
Other Professionals i.e. School		
Other		

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Additional information about this child/families support network: (e.g. formal support, non-formal support from family members, friends and/or other voluntary organisations)

Which Location(s) is Required? (please tick appropriate boxes)

Demelza Kent

Demelza South East London

Demelza Community - East Sussex

Desired Outcomes:

What are the Key Aims of this Referral?: (What are this child's/family's needs?)

If this referral relates to End of Life Care or Bereavement, please contact the appropriate Head of Care directly by telephone to notify them.

Head of Care

Kent

Tel: 01795 845200

Fax: 01795 845281

Head of Care

South East London

Tel: 020 8859 9800

Fax: 020 8859 9838

Community Services Manager

Community East Sussex

Tel: 01323 446461

Fax: 01323 446462

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Referrer(s) details:

This referral must have been fully discussed with parents/carers and young people. Demelza will be unable to progress the referral without written consent.

Name:

Address:

Telephone:

Mobile:

Fax:

Email:

Other Contact:

Job title: (If not family member)

Organisation:

Confidentiality, Data Protection & Consent Statement to be completed by young person / parent / carer

Demelza Hospice Care for Children will process your information in accordance with the UK and EU Data Privacy Regulations and other relevant regulations, and will always store your personal details securely. The Act sets out certain requirements for the protection of your personal information against unauthorised use or disclosure. Except to the extent we are required or permitted by law, the information which you provide in this referral form, and any other information obtained or provided during the course of your referral will be used solely for the purpose of assessing your referral. We'll communicate with you in the way(s) that you have agreed to about relevant Demelza services.

- If your referral is unsuccessful, or you choose not to accept any offer we make, the information you provide will be held on file for a period of six months, after which time it will be destroyed in a secure manner.
- If your application is successful, the information will form part of the clinical file and we will be entitled to process it for all purposes in connection with the services being provided, including family support and therapy services provided to parents, carers and siblings. The Act gives you certain rights. If you wish to access information held about you, or for people in your care, or to make amendments to your information please contact dataprotection@demelza.org.uk.

Demelza regularly work with health and social care commissioners who can provide additional funding for services provided. We are sometimes asked to provide patient details in order to evidence the work that we do.

We always take the safety and wellbeing of children and vulnerable adults seriously. If a child or adult is suspected of being at risk of serious harm, all Demelza staff have a duty of care to share relevant information with key professionals for safeguarding purposes, such as a the child's named Social Worker, GP, etc. When a new referral is received, we will make proportionate enquiries around safeguarding and risk with involved social care professionals as part of our assessment process.

For full details see our Privacy Policy on our website (www.demelza.org.uk/privacy-policy) or contact 01 795 845200 or email dataprotection@demelza.org.uk.

I consent to the use of my personal information for the purposes and on the terms set out above, and give permission for Demelza to write to professionals involved in my child's/young person's care to request relevant information regarding this referral.

Name of Child: **Date of Birth:**

I confirm that I have parental responsibility for the above child and consent to Demelza staff having copies of correspondence and to them sharing information with other professionals involved.

Signed:

Name: (Block Capitals)

Relationship to Child:

Date:

Please send this completed form to:

Referrals & Service Engagement Manager, Demelza Hospice Care for Children, Rook Lane, Bobbing Sittingbourne, Kent ME9 8DZ. Tel: 01795 845195 Fax: 01795 845281

Registered Charity Number: 1039651

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