Shooting Star Chase
Children's Hospice Care

CARE SERVICE REFERRAL FORM

Please complete as fully as possible. If a section is not appropriate for the young person you are referring then please state N/A within that section. For clarity the term 'young person' relates to all those referred between the ages of 0 – 19 years.

DETAILS OF THE YOUNG PERSON BEING REFERRED

Family Name		**Given Names**
D.O.B.	**SEX:**	**NHS No:**
HOME ADDRESS		
HOME TELEPHONE No:		
E-MAIL ADDRESS		
CARER 1 - Name		**Relationship to young person**
Mobile Telephone No:		
CARER 2 – Name		**Relationship to young person**
Mobile Telephone No:		
ETHNIC ORIGIN:	**RELIGION:**	**FIRST LANGUAGE:** **Interpreter Required? Yes / No**

DIAGNOSIS

1)
2)
3)
4)
5)
Allergies:

SIBLINGS

Name & Surname (if different)	Date of Birth	Sex	Affected by same or other condition	Date of Death

Full Medical Background & Current Treatment (please attach any relevant medical summaries)

CCG:		**Local Authority:**	

Are either of the following in-place for this young person?	YES*	NO
Emergency Care Plan / Advance Care Plan		
Symptom Guidelines		

*Please attach a copy

CURRENT TREATMENTS / MEDICATIONS

MEDICATION	DOSE & ROUTE	FREQUENCY
1)		
2)		
3)		
4)		
5)		
6)		

PROFESSIONAL INVOLVEMENT

PROFESSIONAL DESIGNATION AND NAME	PRACTICE / HOSPITAL ADDRESS	CONTACT TELEPHONE NUMBER AND E-MAIL ADDRESS
GENERAL PRACTITIONER		
HOSPITAL PAEDIATRICIAN		
COMMUNITY PAEDIATRICIAN		
COMMUNITY NURSE		
HEALTH VISITOR		
SOCIAL WORKER		
PHYSIO / O.T.		
SPEEECH & LANGUAUGE		
DIETICIAN		

CURRENT FAMILY SITUATION

Details of other Children's Hospice referred to	
Details of other Children's Hospice currently used and level of service offered	

WHAT SUPPORT WOULD THE FAMILY LIKE FROM SHOOTING STAR CHASE?

Hospice of Choice	**Shooting Star House (Hampton)**		**Christopher's (Guildford)**	

Has the parent / legal guardian agreed to this referral? Yes / No

- *To proceed please attach the signed Consent to Release of Medical information Form*

IS THE YOUNG PERSON SUBJECT TO ANY OF THE FOLLOWING?

	YES	NO
Current / previous Safeguarding concerns		
Domestic abuse within the family home		
Significant mental health issues in either parent / carer		
Interim Care Order		
Full Care Order		
Residence Order		

Details of Above

Who has parental responsibility for this young person?

REFERRER'S DETAILS

NAME	DESIGNATION
ADDRESS	
CONTACT TELEPHONE NUMBER: E-MAIL ADDRESS:	

REFERRER'S SIGNATURE: _____

DATE OF REFERRAL: _____

PLEASE RETURN TO: Referral Administration
Shooting Star Chase
Shooting Star House
The Avenue
Hampton
Middlesex TW12 3RA
Tel: 020 8783 2000
Fax: 020 8783 2005

FOR OFFICE USE ONLY	
DATE REFERRAL RECEIVED:	

Consent of Parent/Guardian to Release of Medical Information

I ..... Parent/guardian of:

Young person's name .....

Date of Birth .....

Address .....

.....

.....

NHS Number:	

Give permission for Shooting Star Chase children's hospice service to request medical information from the General Practitioner, Consultant Paediatrician(s) and other professionals involved in the care of my child named above.

Signature of parent/Guardian .....

Printed name .....

Date .....