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| **Lifetime Referral Form** |
|  |
| **Child’s Surname:** | Click here to enter text. | **Child’s First Name:** | Click here to enter text. |
|  |
| **Previous Surnames:** | Click here to enter text. | **M/F** | Click here to enter text. | **Date of Birth:**  | Click here to enter text. |
|  |  |
| **Home Locality:**  | Choose an item. | **First Language:** English [ ] (tick or write) Other: Click here to enter text. |
|  |
| **Religion *(write in or tick one):*** | Click here to enter text. | **Ethnicity *(write in or tick one):***  | Click here to enter text. |
| Not stated [ ] Preferred not to say [ ]  | Not stated [ ] Preferred not to say [ ]  |
|  |
| **Primary Diagnosis:** *(Please give as much detail as possible, include diagnosis dates)* | Click here to enter text. |
| **Secondary Diagnosis:**  | Click here to enter text. |

 **Please tick one of the following:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Life Limiting:** |[ ]   | **Known allergies:** | Click here to enter text. |
| **Life Threatening:** |[ ]   |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Named Nurse:** | Click here to enter text. | **Named Psychologist:** | Click here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date Referred:** | Click here to enter text. |  |  |
| **Name of Referrer:** | Click here to enter text. | **Referrer Contact Details:** | Click here to enter text. |
| **Position of Referrer:** | Click here to enter text. | **Referrer Email Address:** | Click here to enter text. |
| **Any further details:** | Click here to enter text. |
| **Parent/Carer Details** |
| **Name:** | Click here to enter text. | **Telephone:** | Click here to enter text. |
| **Address:** | Click here to enter text. | **Mobile:** | Click here to enter text. |
| **Postcode:** | Click here to enter text. | **Email address:** | Click here to enter text. |
| **Sibling Names:** | **DOB:** |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| **GP** |
| **Name:**  | Click here to enter text. | **Telephone:** | Click here to enter text. |
| **Address:**  | Click here to enter text. | **Mobile:** | Click here to enter text. |
| **Postcode:**  | Click here to enter text. | **Email address:** | Click here to enter text. |

**Referral for South Gloucestershire and Bristol**: Referrals can be made for a child with any life limiting or life threatening condition where the child is not expected to live beyond 40 years of age (apart from children who have cystic fibrosis or cancer as they have their own specialist teams based at Bristol Children’s hospital).

**Referral for North Somerset:**Referrals can be made for a child with any life limiting or life threatening condition where the child is not expected to live beyond 40 years of age (apart from children who have cystic fibrosis or cancer as they have their own specialist teams based at Bristol Children’s Hospital). In this area a referral can also be made for children who have an acute, specific nursing need e.g. short intravenous antibiotics or wound care.

**Referral for to the Continuing Care Team:** Children with long term invasive ventilation needs (via tracheostomy); children who are assessed to require additional, on-going health care support provided by a care package (as assessed by the National Framework 2010).

**Referral for the Clinical Psychology Team:** Referrals to Psychology cannot be made unless a child is receiving a service from the Lifetime nursing team. Referrals can be made via the Lifetime named nurse. See Psychology and referral section for further information about criteria for referral.

**Please return this form to: The Lifetime Service, Corum One, Corum Office Park, Crown Way, Warmley, Bristol, BS30 8FJ or** **SIRCH.Lifetime@NHS.net**