

**Community referral form for Blood Tests**

***Carried out by Paediatric Nurses at Westgate House Children’s Centre, Southmead Hospital***

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| **Name of Child:** | **Parent/carer name:** |
| **NHS Number:** | |
| **Date of Birth:** | |
| **Child’s Address & Post Code:** | |
| **Parent/carer contact number:** | |
| **Name of referring professional:**  **Professional Role:**  **Contact number:** | |
| **Date of Referral:** | |
| **Blood test required:**  **(Please request bloods on the NBT ICE system)**  **Reason for blood test:** | |
| **When is test required: *(Please note: We do not perform Urgent bloods test as we may not have immediate availability).*** | |
| **GP name:**  **Contact no:** | |
| **Health Visitor or Community Midwife’s telephone no (If applicable):** | |
| **Date blood test performed:**  **By whom:**  **Location of Venepuncture:** | |
| **Referring Healthcare professional notified of completion of blood test YES / NO** | |

**Please use ‘Save As’ function and email completed form (as an attachment) to:** [**PaediatricOutpatients@nbt.nhs.uk**](mailto:PaediatricOutpatients@nbt.nhs.uk?subject=Outpatient%20blood%20test%20request) KT Nov 2022