

**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** KT Nov 2022