**Provide Children’s Community Nursing Referral**

**Telephone: 0300 1310 111**

**E-mail Address: provide.ccnteam@nhs.net**

Note: CECS services work to NHS Connecting for Health policies and can only send responses including patient identifiable details (PID) to email addresses that are approved by them. If you are not using an approved email address this may limit the response we can make by email.

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| --- | --- |
| Date of Referral: | NHS Number: |

|  |  |
| --- | --- |
| **Patient Details** | |
| Forename: | Surname: |
| Address and Postcode:  Parents email address: | |
| Date of Birth: | Gender: |
| Home Telephone: | Mobile Telephone: |
| Ethnicity: (see over for further information): | |

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| --- |
| Additional Information (inc safeguarding concerns): |

|  |  |
| --- | --- |
| **GP Details** | |
| Registered GP/Address: | Telephone: |
| GP Practice: | Fax: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Has Parent/Carer given consent for this referral |  | Yes |  | No |
| Date consent given: | | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Family Information** | | | | | | | | | | |
| Name of Parent/Carers (with parental responsibility) | | | | | |  | | | | |
| Names of other adults living at the child’s address | | | | | |  | | | | |
| Name and Age of Siblings: | | | | | |  | | | | |
| Language spoken at home and child’s preferred means of communication | | | | | |  | | | | |
| Child Protection Register |  | Yes |  | No | Looked After Child | |  | Yes |  | No |
| **If Yes then please ensure you supply Social Worker & Contact Details**: | | | | | | | | | | |

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| **Main Reason for referral** |
| Diagnosis (if known) or identified areas of difficulty for which further assessment/treatment may be required: Please include any previous advice, treatment or contact with the service. |
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| **Current medication** |
| Please detail: |
| **Allergy Status** |
| Please detail: |

|  |  |  |
| --- | --- | --- |
| **Referrer Details** |  |  |
| Name: | Job Role: | |
| Organisation\Service:  Address | Telephone: | |
| Consultant responsible for care (if referring from hospital): | Date: | |

**Please ensure that this form is completed fully as incorrect or incomplete forms will be returned.**

**PATIENT ETHNICITY**

|  |  |  |  |
| --- | --- | --- | --- |
|  | White British |  | Pakistani or British Pakisani |
|  | British or Mixed British |  | Bangladeshi or British Bangladeshi |
|  | Irish |  | Other Asian background |
|  | Other white background |  | Caribbean |
|  | White and Black Caribbean |  | African |
|  | White and Black African |  | Other African Background |
|  | White and Asian |  | Chinese |
|  | Other Mixed Background |  | Other |
|  | Indian or British Indian |  | Ethnic Category not stated |