**Specialist Healthcare Training Service Referral Form**

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| --- | --- |
| **Child’s Name:** |  |
| **D.O.B:** |  |
| **Sex:** |  |
| **NHS number:** |  |
| **Date of referral:** |  |
| **Child’s address:** |  |
| **Parent’s telephone number/s :** |  |
| **Parent’s email address:** |  |
| **Child’s diagnosis:** |  |
| **Child’s school:** |  |
| **Short Breaks Passport ID\*:** | \*essential for short breaks and activities |
| **GP name and address:** |  |
| **Name of Social Worker:** |  |
| **Name of Paediatrician and location:** |  |
| **Name of Dietitian:** |  |

|  |  |
| --- | --- |
| **Name of referrer:** |  |
| **Job title:** |  |
| **Company:** |  |
| **Contact telephone number:** |  |
| **Email address:** |  |

**Training Needs**

Please mark a cross in the boxes below for all of the healthcare needs that the child has, and the required specialist healthcare tasks that you require your staff to be trained in.

|  |  |  |  |
| --- | --- | --- | --- |
| **Healthcare Need** | | **Specialist Healthcare Task** | |
|  | **Epilepsy**  *You will need to provide an epilepsy care plan signed by a medical prescriber and dated within the last 12 months.* |  | Buccal Midazolam |
|  | Rectal Diazepam |
|  | Rectal Paraldehyde |
|  | VNS |
|  | | | |
|  | **Enteral Feeding**  *You will need to provide an enteral feeding regime from the child’s Dietitian in order for us to prepare a care plan for your use.* |  | Bolus Gastrostomy Feeding |
|  | Pump Gastrostomy Feeding |
|  | Bolus Jejunostomy Feeding |
|  | Pump Jejunostomy Feeding |
|  | Bolus Nasogastric Tube Feeding |
|  | Pump Nasogastric Tube Feeding |
|  | | | |
|  | **Anaphylaxis**  *Please provide a copy of the child’s allergy care plan if they already have one in place.* |  | EpiPen Autoinjector |
|  | JEXT Autoinjector |
|  | Emerade Autoinjector |
|  | Use of asthma inhaler and spacer device |
|  | | | |
|  | **Oxygen** |  | Oxygen via face mask |
|  | Oxygen via nasal prongs |
|  | | | |
|  | **Oral Suction** |  | Devilbiss suction unit (grey box) |
|  | Devilbiss QSU suction unit (blue and grey) |
|  | Medella Clario suction unit |
|  | Laerdal portable suction unit |
|  | | | |
|  | **Other**- please provide details, e.g. tracheostomy, ventilation, central line etc. |  |  |

**Training Requirements**

* There are 2 parts to our training;
  + Awareness training on the subject which is valid for 2 years.
  + Competency assessments for each specialist healthcare task that the child requires. Competencies will be updated annually.
* Staff will be required to watch a training video or videos and then have a follow up video call with a member of our nursing team. Please ensure that your staff have access to IT equipment to facilitate this. Where necessary, face to face training will also be arranged.
* We usually train a maximum of 5 staff per child in each setting. If you require more staff to be trained, please call us to discuss this first.
* If your staff have received training from another provider, please provide evidence of this training with your referral.
* Please ensure that the staff named below are aware that they have been nominated for specialist healthcare training and that a member of our service will be in contact with them once your referral has been approved.
* If staff have any special learning needs, please tick the box next to their name and we will contact them direct to discuss the best way to facilitate their training. For confidentiality- please do not add any details to this form.

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| --- | --- | --- | --- | --- | --- | --- |
|  | **Name** | **Job title** | **Email address** | **Telephone No** | **Any learning needs?** | **Prior training with SHT?** |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |

**Consent Form**

This form must be physically signed by the parent or a named person with parental responsibility for the child named below. We are unable to accept signatures typed as text.

Please note that without signed and valid consent, we are unable to process your referral and deliver training.

Please be aware that our training may take place either face to face in your child’s setting or via a secure video call.

|  |  |
| --- | --- |
| **Name of Child/ Young Person:** |  |
| **NHS Number:** |  |
| **Date of Birth:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I give permission to the Specialist Healthcare Training Team to request, receive and share information relating to my child from and with all agencies involved in their care and support. I understand that this referral will remain in place for the duration of my child’s involvement with the provider detailed on this form, e.g., school or short breaks club. | | | | |
| **Name of person giving consent:** |  | | | |
| **Relationship to the child:** |  | | | |
| **Contact telephone number:** |  | | | |
| **Do you consent to your child’s records being used for audit and evaluation purposes?** |  | Yes |  | No |
| **Signed:** | Please note this must be physically signed and not typed | | | |
| **Date signed:** |  | | | |

Please email your completed form to: [PROVIDE.specialisthealthcare@nhs.net](mailto:PROVIDE.specialisthealthcare@nhs.net)

Form Reviewed: 31.05.23