CHILDREN'S COMMUNITY NURSING TEAM REFERRAL FORM

Please indicate (circle) which team you are referring to

Pennine Care NHS Foundation Trust

NHS Manchester Manchester Community Health

Bury CCNT	HMR CCNT	Oldham CCNT	Manchester CCNT
Fax 0207 019 8252	**Fax** 0207 019 7419	**Fax** 0161 621 3885	**Fax** 0161 248 6267
Tel 0161 724 2137 **Email** srh-tr.ccnt-bury@nhs.net	**Tel** 01706 676 777 **Email** pcn-tr.HMRchildrensAONS@nhs.net	**Tel** 0161 621 3870 **Email** srh-tr.ccntoldham@nhs.net	**Tel** 0161 248 8501

Surname Name	**Consultant**	**NHS No**
First name	**DOB** **M/F**	**Ward/Dept ……..……..** **Discharged by ...……..**
Address **Post Code**	**Parents/ Guardian Names** **Interpreter needed** **Y/N** **Language**	**Contact No ……..** **Date of Admission ……..** **Date of Discharge ……..** **Time of discharge ……..** **Date of Surgery ……..** (if applicable)
Phone No **Mobile No** **GP Name** **Address** **Postcode** **Phone No**	**Ethnicity** White ☐ Black – Caribbean ☐ Black – African ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Other (Please state)……	**Is the Child subject to a protection plan?** Or A Looked after child Or A Child in need Any other risk factors e.g. Domestic Violence …… Any other agencies involved……... ……

Diagnosis – Reason for Referral	**Date of first visit / contact required**

Relevant Information, Nursing & medical needs

Discharge observations

Respirations	Heart Rate	SaO2	Temperature	Weight

Discharge Medication