**CHILDREN’S COMMUNITY NURSING TEAM REFERRAL FORM**

|  |  |
| --- | --- |
|  | **MCH colour.jpg** |
| **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**pcn-tr.ccnt.bury@nhs.net | **Tel** 01706 676 777**Email**pcn-tr.HMRchildrensAONS@nhs.net | **Tel** 0161 621 3870**Email**pcn-tr.CCNTOldham@nhs.net | **Tel** 0161 248 8501 |

**Please indicate (circle) which team you are referring to**

|  |  |  |
| --- | --- | --- |
| **Surname Name** | **Consultant** | **NHS No** |
| **First name**  | **DOB M/F** | **Ward Department****…………………………………………..****Contact No****…………………………………………..****Date of Admission ………………….****Date of Discharge …………………..****Date of Surgery ……………………..**(if applicable) |
| **Address****Post Code** |  **Parents/ Guardian Names** |
| **Interpreter needed Y/N** |
| **Language** |
| **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 childOr A Child in needAny other risk factors e.g. Domestic Violence ………………………………Any other agencies involved………...…………………………………………. |
| **Mobile No** |
| **GP Name** **Address****Postcode****Phone No** |
| **Diagnosis – Reason for Referral** | Date of first visit / contact required |
| Relevant Information, Nursing & medical needs |
| Discharge observations**Weight** |
| **Respirations** | **Heart Rate** | **SaO2** | **Temperature** |
| Discharge Medication |

**Updated & amended January 2018 (amended & shared by Oldham CCNT) DP & EM**