Antenatal referral

children's hospice SOUTH WEST

To be completed by the Antenatal Team

If this is an urgent, fast track referral, please call the relevant hospice, ordinarily this is the hospice closest to the child's home address, Little Bridge House in Devon 01271 321 999, Charlton Farm in North Somerset 01275 866 611, Little Harbour in Cornwall 01726 65 555. Otherwise please complete the form below in BLOCK CAPITALS and together with the completed Antenatal parent or carer consent, return to: Care Team Admin, Children's Hospice South West (head office), Little Bridge House, Redlands Road, Fremington, Barnstaple EX31 2PZ or email: careteam.lbh@chsw.org.uk

Details of baby

First name (if known):	Surname:
Expected date of delivery:	Gender (if known):
Ethnic group, (if known):	Religion, (if known):
Integrated Care Board (ICB), (if known):	
Hospital where antenatal care is provided:	
Hospital planned for delivery:	

Obstetrician

Name:	Tel:
Email:	

Fetal medicine team

Name:	Tel:
Email:	

Midwife

Name:	Tel:
Email:	

Antenatal referral

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NICU Team

Name:	Tel:

Email:

Main diagnosis/reason for referral:

Investigations to date:

What is the parent's understanding of their condition and prognosis?

Parents wishes as understood so far:

Relevant maternal/antenatal history:

Antenatal referral

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NICU Team continued

Details of any planned appointments/reviews:

Delivery plans such as expected dates, likely mode of delivery:

Details of any advance care planning or resuscitation discussions so far:

Details of any anticipated symptoms to be planned for:

Parent or carer 1

Parental responsibility: ☐ Yes ☐ No

First name:

Surname:

Address:

Relationship to child:

Home tel:

Postcode:

Mobile tel:

Email:

First language:

Interpreter required: ☐ Yes ☐ No

Additional/health needs:

Parent or carer 2

Parental responsibility: ☐ Yes ☐ No

First name:

Surname:

Address:

Relationship to child:

Home tel:

Postcode:

Mobile tel:

Email:

First language:

Interpreter required: ☐ Yes ☐ No

Additional/health needs:

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Sibling 1

First name:

Surname:

Address (if different to overleaf):

Date of birth:

Gender:

Additional/health needs:

Postcode:

Sibling 2

First name:

Surname:

Address (if different to overleaf):

Date of birth:

Gender:

Additional/health needs:

Postcode:

Sibling 3

First name:

Surname:

Address (if different to overleaf):

Date of birth:

Gender:

Additional/health needs:

Postcode:

Sibling 4

First name:

Surname:

Address (if different to overleaf):

Date of birth:

Gender:

Additional/health needs:

Postcode:

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Other professionals involved

Does the child have a social worker and/or disability social worker? ☐ Yes ☐ No
If yes, please include details in 'Other professionals area'

Are there any safeguarding, needs such as a child protection plan in place? ☐ Yes ☐ No

GP

GP name:

Practice:

Address:

Tel:

Postcode:

Email:

Other Professional

Name:

Professional role:

Address:

Tel:

Postcode:

Email:

Other Professional

Name:

Professional role:

Address:

Tel:

Postcode:

Email:

Other Professional

Name:

Professional role:

Address:

Tel:

Postcode:

Email:

Antenatal referral

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Any other relevant information:

Referrer's details

First name:	Surname:
Address:	Relationship to child:
	Tel:
	Postcode:
Email:	
Signature:	Date:

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