FOR THE FAMILY

## **YOUR REFERRAL TO NOAH’S ARK CHILDREN’S HOSPICE**

## Your child has been referred to Noah’s Ark Children’s Hospice. If you are unaware of this or no longer consent, please discuss with the referrer.

We welcome the referral of babies, children and young people who met our referral criteria and live within our core catchment area of Barnet, Camden, Enfield, Haringey, Hertsmere and Islington. We consider referrals outside our catchment area in exceptional circumstances and on a case-by-case basis, in discussion with the lead hospice for the area.

**WHAT HAPPENS NEXT?**

All referrals are given careful consideration on receipt. If the referral is for Emergency, End of Life or Care After Death we will respond urgently and contact you directly. All other referrals will be considered at our next multidisciplinary panel meeting which will be within two weeks.

If we have all the information needed to make a decision of acceptance promptly, we will allocate a Family Link Worker who will contact you to arrange a home visit to start the Assessment process.

We may need to seek further information from medical professionals involved with your child’s care such as consultants or your GP. In order to process your referral in a timely manner, please ensure an NHS number is provided on the referral form and attach an up-to-date clinic letter.

**WHAT IF MY CHILD IS NOT ACCEPTED?**

Sadly, we cannot offer support to every baby, child or young person referred to us. Our primary focus is on those babies, children or young people who meet our criteria. If your child is not accepted, we may be able to suggest other services you can consider contacting.

You are free to speak to us at Noah’s Ark Children’s Hospice to ask us to reconsider a decision if you think there are factors, we may have overlooked. Re- referrals are welcome at any time, should your child’s condition change.

If you have any questions, please contact us on: **0208 449 8877** or email [**noahs.referrals@nhs.net**](mailto:noahs.referrals@nhs.net)

A cartoon of a child and a child in a wheelchair

AI-generated content may be incorrect.

**REFERRAL FORM FOR ALL CARE SERVICES**

**REFERRAL TYPE**

**Routine**  **Urgent admission**  **End of life**

Noah’s Ark Children’s Hospice accepts referrals for children under 18 years based on the following criteria, in line with guidelines used by Children’s Hospices.

|  |  |  |
| --- | --- | --- |
| **GROUP 1** | Life threatening conditions for which curative treatment may fail, e.g. cancer, irreversible organ failure. | **Yes/No** |
| **GROUP 2** | Conditions where premature death is anticipated but intensive treatment may prolong life e.g. complicated cystic fibrosis, HIV. | **Yes/No** |
| **GROUP 3** | Progressive conditions without curative treatment options where treatment is exclusively palliative e.g. Battens disease, mucopolysaccharidoses. | **Yes/No** |
| **GROUP 4** | Conditions causing severe neurological disability leading to susceptibility of health complications and likelihood of premature death e.g. severe cerebral palsy, multiple disabilities following brain or spinal cord insult. Group 4 children may need to undergo further assessment if eligibility is not clear using this criteria**.** | **Yes/No** |

## **CHILD’S DETAILS**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Child’s last name |  | | | Child’s first name | | |  | | |
| Child’s NHS no. |  | | | Child’s age | | |  | |
| Date of birth |  | | Male/Female/Non-binary | | | |  | |
| Ethnicity |  | | | | Religion | |  | |
| Family address |  | | | | | | | |
| Borough |  | | | | Postcode | |  | |
| Tel no. |  | | | | Email |  | | |
| Primary language | |  | | | Interpreter required? Yes/No | | |  |

**PARENTS / CARER DETAILS**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Last name |  | | First name |  | | Title |  |
| DOB |  | Relationship to child |  | | Do they have parental responsibility? | **Yes/No** | |
| Are they the main carer? | | **Yes/No** |
|  | | | | | | | |
| Last name |  | | First name |  | | Title |  |
| DOB |  | Relationship to child |  | | Do they have parental responsibility? | **Yes/No** | |
| Are they the main carer? | | **Yes/No** |
|  | | | | | | | |
| Details of shared care arrangements (if applicable): | | | | | | | |

**SIBLINGS DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Last name | First name | DOB | Gender? **M/F** |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |

**General Practitioner**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| GP name |  | Telephone | | |  |
| Address and postcode |  | | | | |
| ICB |  | | Email |  | |

**SCHOOL DETAILS**

|  |  |  |
| --- | --- | --- |
| Contact name and position | Name and address of school | Telephone number and email |
|  |  |  |

**PROFESSIONAL’S DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of professional | Role | Address | Telephone number and email |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

## **MEDICAL DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Diagnosis: | | | |
| Please specify all medical conditions and care needs: | | | |
| Date diagnosed (approx) |  |
| Likely prognosis: | | |

Current phase of illness – please check one box:

Stable  Unstable  Deteriorating  Dying  Unknown

**Please attach any relevant documentation such as a recent clinic letter to support the application.**

## **ADVANCE PLANNING**

Is there an Advance Care Plan / ReSPECT document in place? Yes  No

If yes, please attach or supply further details below. If no, what discussion have taken place?

|  |
| --- |
|  |

Is there a Symptom Management Plan? Yes  No

Please give a brief description of how you feel Noah’s Ark can help the child and family referred. Please include any additional information you feel would be helpful with this referral.

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| --- |
|  |

Who or what prompted you to make this referral?

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| --- |
|  |

## **IF THERE ARE SAFEGUARDING CONCERNS, PLEASE GIVE BRIEF OUTLINE:**

|  |
| --- |
|  |

**Please tell us if the child subject to any of the following:**

Child Protection Plan  Child in Need Plan  Care Order  Child Arrangements Order

Special Guardianship Order  Child in Care; by voluntary agreement (s.20)

## **PLEASE DETAIL CURRENT CARE PACKAGE:**

|  |  |
| --- | --- |
| Social Care (short breaks / care hours/ overnights / personal budget): | Continuing Care (care hours / overnights / personal health budget): |
| Allocated Social Worker and telephone number: | Continuing Care Matron and telephone number: |

**REFERRER’S DETAILS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Full name |  | | | | Role/relationship to child | | |  |
| Address |  | | | | | | Postcode |  |
| Tel no. |  | | | Email | |  | | |
| Date of referral | |  |

**How did you hear about Noah’s Ark?**

Already working in partnership  Local professional networking  Noah’s Ark Presentation

Noah’s Ark Fundraising Event  Family or Friend  GOSH crèche/music therapy service

Other, please state:

|  |
| --- |
|  |

## **CONSENT TO REFERRAL AND TO SEEK AND SHARE INFORMATION**

**For those unable to consent and children under 16:**

I, the parent/guardian, give consent to the referral.  Yes  No

**For young people aged 16 years or above:**

Does the young person have capacity to consent to the referral?  Yes  No

If so, has consent been given to the referral?  Yes  No

In order to provide safe and effective care, Noah’s Ark Children’s Hospice will need to obtain or share your child’s up to date personal details, and general medical & social care information, including clinic letters, copies of prescriptions (FP10), emergency care plans and advance care plans from other professionals including (but not limited to) schools, community teams, GPs, hospitals, local authorities and/or clinical commissioning groups.

**I give permission for Noah’s Ark Children’s Hospice to seek and share health and social care information as outlined above:**  Yes  No

Please note that by making this referral it may be necessary for us to request further medical information as

necessary.

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer’s signature |  | Date |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Carer’s signature |  | Date |  |

Please send the completed form to us by post or email. If you are emailing outside of the nhs.net network, please

note that this is not secure so please password protect the sent documents and send the password in a separate

email.

Post: **The Ark, Byng Road, Barnet EN5 4NP** | Email: [**noahs.referrals@nhs.net**](mailto:noahs.referrals@nhs.net)

Referrals for Urgent / End of Life Care or Care After Death through Noah’s Ark Children’s Hospice can be directed to the 24/7 Nurse-on-Call number: **020 3994 4134**. Please leave a message and your call will be returned within 1 hour. The on-call Registered Nurse can advise on the referral immediately or plan a call back following discussion with the Referral Panel Members. Urgent referral forms be emailed to noahs.nurses@nhs.net