# PERINATAL REFERRAL FORM

This form is to be used for professional referral of a family where there has been a diagnosis of an abnormality in pregnancy, late miscarriage, ending of pregnancy due to foetal anomaly or stillbirth. If a baby has been born alive and will have palliative care needs, please use the general referral form.

|  |  |  |  |
| --- | --- | --- | --- |
| Has the baby been born? | Yes | Has the baby died? | Yes |
| No | No |

**DETAIL S OF BABY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Family surname |  | Forename(s) (if applicable) |  | Date of death (if applicable) |  |
| Date of birth (if applicable) |  | Expected date of delivery (if applicable) |  | Gestation  (if applicable) |  |
| Diagnosis  (if applicable) |  | Multiple birth? |  | Birth weight |  |

|  |  |
| --- | --- |
| Gender | Male |
| Female |
| Indeterminate |
| Not known |

|  |  |
| --- | --- |
| Family home address, including postcode |  |
|
|

**PARENTS / CARER DETAILS**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Last name** | | | **First name** | | | **Title** | **DOB** | | **Relationship to child** | | **Do they have parental responsibility?** (Yes/No) |
|  | | |  | | |  |  | |  | |  |
|  | | |  | | |  |  | |  | |  |
| Religion |  | | | Ethnicity |  | | | Telephone numbers | |  | |
| Primary language(s) | |  | | | | | | Interpreter required? (Yes/No) | |  |

|  |  |  |
| --- | --- | --- |
| **Mother’s history** | **Please give information regarding:**  Gravida and parity Any complications  Milk donation / Milk suppression |  |
| **Family information** | **Please give information regarding:** History of miscarriage, stillbirth or neonatal death; additional needs of family members; spiritual and religious wishes; mental health |  |

**SIBLING DETAIL S**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last name** | **First name** | **DOB** | **Gender** (Female/Male) |
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**PROFESSIONAL S INVOLVED WITH THE FAMILY**

**General Practitioner**

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

**Professionals involved**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name and title** | **Address** | **Telephone** | **Email** | **Type and frequency of support and service provided** |
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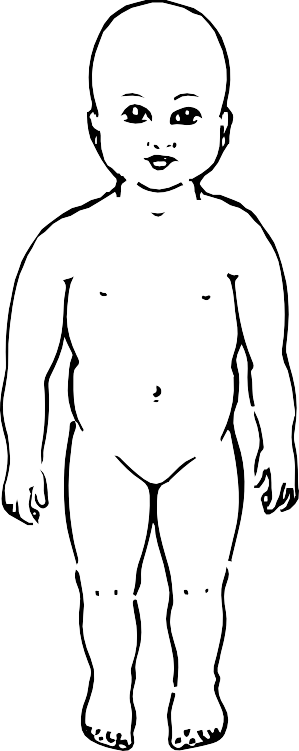
**FURTHER INFORMATION**

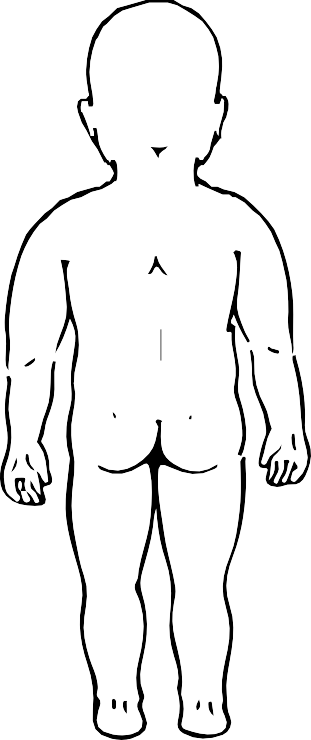
|  |  |
| --- | --- |
| **FOETAL ANOMALY**  Please detail: birth plan/parallel plan, if known; how the anomaly was detected (scan/bloods/ CVS/amino); date of foetal medicine scan; discussions regarding wishes post-death. |  |
| **PREGNANCY ENDED** (pre-24 weeks)  If the pregnancy has ended, please tell us the likely reason. If the pregnancy has, or is expected to, end, what are the plans for delivery? |  |
| **STILLBIRTH**  Please tell us a little about the birth, so we have a better understanding of the parents’ experience, ie resuscitation attempted/any complications. |  |
| **NEONATAL DEATH**  Please tell us a little about the death, so we have a better understanding of the parents’ experience, ie interventions or measures offered/withdrawn. |  |

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| --- | --- | --- |
| **Has the death been registered?** (Please answer Yes, No or N/A) |  | Please provide any relevant details: |
| **Are funeral directors identified?** (Please answer Yes, No or N/A) |  | Please provide any relevant details: |
| **Is care after death being requested? If so, how will the baby be transported to the hospice?** | Details: | |
| **Are Noah’s Ark needed to support with funeral arrangements?**  (Please answer Yes, No or N/A) |  | Please provide any relevant details: |
| **Would parents like any further memory making / keepsakes?**  (Please answer Yes, No or N/A) |  | Please provide any relevant details: |

Please describe and indicate any dysmorphic features, equipment or lines in place, and current skin condition:

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| --- |
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**Draw and label the map**



|  |  |  |  |
| --- | --- | --- | --- |
| 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, London EN5 4NP** | Email: **noahs.referrals@nhs.net**

Referrals for Urgent, End of Life or Care After Death are 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**