

*We are commissioned to provide community nursing services to the children of Oxfordshire (who are registered with an Oxfordshire GP surgery) from birth until the age of 18. We provide nursing support for children with long term and chronic health conditions, acute treatments, respite sessions and palliative/end of life care. If you wish to discuss the suitability of your referral, please contact the CCN SPA 7 days/week on* **(01865) 902 700.**

*Send referrals to:* **CCNTeam@oxfordhealth.nhs.uk**

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| **Patient demographics:**Name: Click or tap here to enter text.D.O.B: Click or tap to enter a date. NHS Number: Click or tap here to enter text.Address: Click or tap here to enter text.GP surgery: Click or tap here to enter text. | **Next of kin details:**Name: Click or tap here to enter text.Relationship to child: Choose an item.Telephone no: Click or tap here to enter text. |

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| **Safeguarding information:**Are the family known to social services? Choose an item.Is the child subject to any of the following? Choose an item.Are there risks to visiting the home address? Choose an item.Please provide any relevant information regarding social history below: Click or tap here to enter text. | **Referral:**Date of referral: Click or tap to enter a date.Name of person completing the referral: Click or tap here to enter text.Designation of person completing the referral:Click or tap here to enter text.Next of kin aware of the referral?Choose an item. Expected discharge date:Click or tap to enter a date. |

**Past medical history / diagnosis:**

*Please provide full details of medical history and diagnosis for children with long term conditions / palliative/ EOL care requirements. For children requiring acute treatments, please detail history of presenting complaint and other relevant medical history.*

Click or tap here to enter text.

**Reasons for referral:\***

*Please note: \***Completed competencies are required before referral will be accepted. 2 weeks supplies of plastics must also be provided on discharge home.* ***\*\**** *We are unable to provide respite for children who do not otherwise meet our referral criteri*

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| **Airway:** [ ]  Artificial airway (Tracheostomy/NPA)**Breathing:**[ ]  Non-invasive ventilation[ ]  HFT / Airvo[ ]  Home oxygen[ ]  O2 saturations[ ]  Suction[ ]  Cough assist**Circulation:**[ ]  Central venous access device[ ]  Blood sampling (from CVAD)[ ]  Blood pressure monitoring  | **Nutrition:**[ ]  NG\*[ ]  NJ\*[ ]  PEG\*[ ]  PEJ\*[ ]  PEG/J\*[ ]  Gastrostomy\*[ ]  Jejunostomy\*[ ]  Gastrostomy button\*[ ]  Jejunostomy button\*[ ]  G/J button\*[ ]  TPN/PN**Support:**[ ]  Palliative / EOL[ ]  Respite\*\* | **Elimination:**[ ]  Urethral catheter[ ]  Suprapubic catheter[ ]  Vesicostomy[ ]  Mitrofanoff [ ]  Urinalysis**Medication support:**[ ]  IV injection/infusion[ ]  IM injection [ ]  S/C injection[ ]  S/C infusion (T34)**Tissue viability:**[ ]  Wound care[ ]  Pressure areas |

**Key professionals:**

*Please list any key professionals involved in the child’s care: (Include consultants, CNS’, therapists, SWs, lead professional etc)*

Click or tap here to enter text.

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| **Equipment required:** *If the child requires any of the following equipment, please also complete a “CCN medical devices form”* ***alongside*** *the referral.* [ ]  Nippy/NIV [ ]  Airvo [ ]  Cough assist [ ]  Sats monitor [ ]  Suction machine | **Medications:***Please detail any medications that the child requires, and if these cause any potential risks within the community i.e. altered pH.* Click or tap here to enter text. |

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| **Complex discharge planning:***Please ensure that you have provided a full outline of nursing needs and medical history and that you have listed all the key professionals involved in the child’s care. (If this section is not relevant for your referral, please leave blank.)*Is the CCN discharge coordinator already aware of child? Choose an item.Is a discharge planning meeting required? Choose an item.**If yes,** has this been planned / requested? Choose an item. **If yes,** please state the planned:**Date:** Click or tap to enter a date. **Time:**Click or tap here to enter text.**Location:** Click or tap here to enter text.  |

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| **Acute treatments:***If your referral is for an acute treatment, please provide details below. (If this section is not relevant, please leave blank.)***Date treatment required from:** Click or tap to enter a date. |
| [ ]  IVABS\* Administration method: Choose an item.Drug name/s: Click or tap here to enter text.Frequency: Click or tap here to enter text.Time of dose/s: Click or tap here to enter text.[ ]  IM injection/s\*Drug name/s: Click or tap here to enter text.Frequency: Click or tap here to enter text.Time of dose/s: Click or tap here to enter text.[ ]  S/C injection/s\*Drug name/s: Click or tap here to enter text.Frequency: Choose an item.Time of dose/s: Click or tap here to enter text. | [ ]  Wound care\*\* Dressing type: Click or tap here to enter text.Frequency: Click or tap here to enter text.[ ]  Blood pressure monitoringFrequency: Choose an item.Target range: Click or tap here to enter text. [ ]  UrinalysisFrequency: Choose an item.Results to: Click or tap here to enter text. |
| **\***Completed DTAs (direction to administer / “community prescription “and full TTOS must be provided for referral to be accepted. **Adrenaline dosage is required on the DTA but does not need to be dispensed**. **\*\*** Current dressings and frequency of dressing changes must be detailed for the referral to be accepted. |

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| **Office / DC use only:** |
| Referral status: Choose an item.Referral received: Click or tap to enter a date.Oxfordshire CCG GP confirmed: Choose an item.Alerts on care notes? Choose an item.Relevant competencies received: Choose an item. | Required DTA’s provided and correct? Choose an item.Discharge letter received: Choose an item.Respite required? Choose an item.Palliative/EOL required? Choose an item.Added to care notes? Choose an item. |