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**Ashgate Hospice Young Person’s Referral Form**

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| **Ashgate Hospice**  Ashgate Road  Old Brampton  Chesterfield  Derbyshire  S42 7J | **Main Reception:** 01246 568801  **Website:** www.ashgatehospice.org.uk  **Email:** supportivecarereferrals@ashgatehospice.org.uk |

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| **Guidance: Please complete ALL sections below.**  **\*\*REFERRALS MAY NOT BE ACCEPTED IF THE REQUESTED INFORMATION IS INCOMPLETE\*\***  **Please return completed forms to the email stated above.** |

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| **YOUNG PERSONS DETAILS** | |
| **Name:**  **Dob:**  **Address:** | **NHS No:**  **GP Details:** |
| **Parent / Carer /guardian**  **Full Name:**  **Contact numbers:** | |
| **Has parent/guardian consented to a referral to Supportive Care Service? Yes / No**  **Has parent/guardian consented to share their health records? Yes / No** | |
| **Who is the person receiving palliative care or RIP – provide details and relationship to Young Person.**  **Is the Young Person in a caring role? Yes / No**  **Is Referral to young carers need? Yes /No** | |
| **School / College:**  **Year group:**  **Please provide details of any other relevant professionals/organisations involved, including CAMHS, Educational Psychology, etc.** | |
| 1. **Presenting issue/precipitating event:** | |
| 1. **Effect on their personal and school life/emotional wellbeing:** | |
| 1. **Please provide information about specific cultural/health/language needs, etc that need to be taken account of:** | |
| 1. **Identify any risk factors – ie: household members, pets, infection control** | |
| 1. **What benefit do you think Supportive Care Service involvement will bring to the client?** | |
| **DETAILS OF REFERRER:** | |
| **Name:** | **Date of Referral:** |
| **Role:** |  |
| **Contact Details:** |