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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:**
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| 1. **Effect on their personal and school life/emotional wellbeing:**
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| 1. **Please provide information about specific cultural/health/language needs, etc that need to be taken account of:**
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| 1. **Identify any risk factors – ie: household members, pets, infection control**
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| 1. **What benefit do you think Supportive Care Service involvement will bring to the client?**
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| **DETAILS OF REFERRER:** |
| **Name:** | **Date of Referral:** |
| **Role:** |  |
| **Contact Details:** |