**For Attention of: CYP Team**

**Jersey Hospice Care, Mont Cochon, St Helier, Jersey JE2 3JB**

**CYP@jerseyhospicecare.com**

**01534 780 780**

[www.jerseyhospicecare.com](http://www.jerseyhospicecare.com)

**For Referrals to Emotional Support or Bereavement Support only, please use separate Referral Form.**

**We accept children and young people with life-limiting and life-threatening conditions between the ages of 0-18 years based on the criteria below, taken from Together for Short Lives. Our service provides nurse led daytime respite care (Monday to Friday 9am-5pm) within the home or in our designated children and young people’s rooms at Jersey Hospice Care.**

There are a wide range of life-limiting and life-threatening conditions affecting children and young people, which can be categorised broadly into four groups.

**Please tick the relevant group:**

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| --- | --- | --- |
| **GROUP 1** | **Life-threatening conditions for which curative treatment may be feasible but can fail** Access to palliative care services may be necessary when treatment fails or during an acute crisis, irrespective of the duration of threat to life. On reaching long-term remission or following successful curative treatment there is no longer a need for palliative care services. Examples: cancer, irreversible organ failures of heart, liver, kidney. |  |
| **GROUP 2** | **Conditions where premature death is inevitable** There may be long periods of intensive treatment aimed at prolonging life and allowing participation in normal activities. Examples: cystic fibrosis, duchenne muscular dystrophy. |  |
| **GROUP 3** | **Progressive conditions without curative treatment options** Treatment is exclusively palliative and may commonly extend over many years. Examples: batten disease, mucopolysaccharidoses. |  |
| **GROUP 4** | **Irreversible but non-progressive conditions causing severe disability, leading to susceptibility to health** Children can have complex health care needs, a high risk of an unpredictable life-threatening event or episode, health complications and an increased likelihood of premature death. Examples: severe cerebral palsy, multiple disabilities, such as following brain or spinal cord injury. |  |

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| **REFERRER** | **Please Tick Relevant Box** |  |
| Are you a Young Person? |  | **PLEASE COMPLETE SECTION B AND C** |
| Are you a Parent / Carer / Guardian? |  | **PLEASE COMPLETE SECTION B AND C** |
| Are you a Healthcare Professional? |  | **COMPLETE SECTION A BEFORE GOING TO SECTION B AND C** |

**SECTION A**

|  |  |
| --- | --- |
| Has the young person or child’s parents (or those with parental responsibility\*) given verbal consent to be referred to the Children and Young People’s Team (CYPT) at Jersey Hospice Care? | Please Tick  Yes  No |
| Has the young person or child’s parents (or those with parental responsibility) given verbal consent for information to be shared with relevant healthcare professionals, share electronic records and to discuss the child/young person with the MDT? | Yes  No |
| If ‘No’ does the young person or child’s parents (or those with parental responsibility) give verbal consent for the CYPT to contact them directly? | Yes  No |

**SECTION B**

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| **REASON FOR REFERRAL** |
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| --- | --- |
| **CHILD/YOUNG PERSON’S DETAILS** |  |
| **FULL NAME** | **LAST NAME** |
| **DATE OF BIRTH** |  |
| **HOME ADDRESS**  **POSTCODE** |  |
| **TELEPHONE NUMBER** |  |
| **PARENT/GUARDIAN NAMES AND CONTACT NUMBERS** |  |
| **FIRST LANGUAGE OF CHILD/YOUNG PERSON/PARENT/GUARDIAN** |  |
| **IS AN INTERPRETER REQUIRED** |  |

|  |  |
| --- | --- |
| **NAME OF REFERRER** |  |
| **RELATIONSHIP TO CHILD OR YOUNG PERSON** |  |
| **CONTACT TEL NO** |  |
| **CONTACT EMAIL** |  |
| **DATE OF REFERRAL** |  |
| **REFERRER’S SIGNATURE** |  |

**SECTION C**

|  |  |
| --- | --- |
| **CHILD / YOUNG PERSON DIAGNOSIS / MEDICAL HISTORY** | |
|  | |
| **ALLERGIES** | Yes / No (please circle) |
| **IF ‘YES’ TO ALLERGY PLEASE DETAIL** |  |

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| --- | --- |
| **PROFESSIONALS INVOLVED** | **NAME** |
| **CONSULTANT(S)** |  |
| **GP** |  |
| **SOCIAL/FAMILY SUPPORT WORKER** |  |
| **KEY NURSE** |  |
| **OTHER** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **COMMUNICATION** | | | |
| Consent given for communication  (please circle) | Postal | Telephone/Text | Email  Email details: |

*\*People with parental responsibility for a child include: the child’s mother; the child’s father if married to the mother at the child’s conception, birth or later; a legally appointed guardian; the local authority if the child is on a care order; or a person named in a residence order in respect of the child. For births registered before 2 December 2016, an unmarried father will not have automatically parental responsibility for his child. In order to acquire parental responsibility, an unmarried father would only have parental responsibility by: applying to the court for an order stating that he has parental responsibility for his child; entering into a parental responsibility agreement with the child's mother, or by requesting that the registrar of the parish in which the child was born, re-registers the child's birth and enters the father's name. This option will involve the cooperation of the child's mother in making the request to the registrar.* *If the child was born on or after 2 December 2016, the father will automatically have parental responsibility for his child provided they are registered as the child's father at the time of the child's birth (named on the birth certificate).*

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| --- | --- | --- |
| **For Hospice use only (must be completed on triage):** | | |
| Contact Young Person / Parent / Guardian: within 48 hours within 2 weeks within 3 weeks  (Please Circle Relevant Contact Above) (Please Tick Relevant Timeframe Above) | | |
| Has this referral been discussed with the child or young person (CYP) and have they agreed to being contacted and offered support? We require all CYP referrals to be discussed with the child or young person if possible and they must consent to being referred if this is appropriate. | | |
| **Other actions:** e.g. contact referrer for more information | | |
| CYPT nurse name and signature: | Date: | Time: |

**Privacy notice**

**The information supplied on this form will be processed in line with the Data Protection (Jersey) Law 2018. It will be shared with health care professionals involved in the child or young person’s care and used for the purposes of providing healthcare professionals access to up-to-date and accurate clinical information. This information is retained and disposed of in accordance with JHC’s retention policy. It will not be shared with further third parties without the child or young person’s consent or unless a condition of the law is fulfilled. For more information about data rights please email** [**dataprotectionofficer@jerseyhospicecare.com**](mailto:dataprotectionofficer@jerseyhospicecare.com)

**Our full privacy notice can be found at** [**https://www.jerseyhospicecare.com/privacy-notice**](https://www.jerseyhospicecare.com/privacy-notice)**.**