NOAH'S ARK
children's hospice

FOR THE FAMILY

YOUR REFERRAL TO NOAH'S ARK CHILDREN'S HOSPICE

Your child has been referred to Noah's Ark Children's Hospice. If you are unaware of this or no longer consent, please discuss with the referrer.

We support children who live within our core catchment area of Barnet, Camden, Enfield, Haringey, Herts Valley and Islington. We are now also able to consider referrals for children living in north west London.

WHAT HAPPENS NEXT?

All referrals are given careful consideration on receipt. If the referral is for Emergency, End of Life or Post Death care we will respond urgently and contact you directly. All other referrals will be considered at our next multidisciplinary panel meeting which will be within two weeks.

If we have all the information needed to make a decision of acceptance promptly, we will allocate a Family Link Worker who will contact you to arrange a home visit to start the Assessment process.

In order to process your referral, we may need to seek further information from medical professionals involved with your child's care such as consultants, your GP etc. It may therefore take longer before a decision is made.

WHAT IF MY CHILD IS NOT ACCEPTED?

Sadly, we cannot offer support to every baby, child or young person referred to us. Our primary focus is on those babies, children or young people who meet out criteria. If your child is not accepted, we may be able to suggest other services you can consider contacting.

You are free to speak to us at Noah's Ark Children's Hospice to ask us to reconsider a decision if you think there are factors we may have overlooked. Re-referrals are welcome at any time, should your child's condition change. If you have any questions, please contact us on: **0208 449 8877** or email **noahs.referrals@nhs.net**

REFERRALS FOR URGENT/END OF LIFE OR POST DEATH CARE

Referrals for Urgent, End of life or Post Death Care through Noah's Ark Children's Hospice can to be directed to the 24/7 Nurse on-Call number: 020 3994 4134 or the Nurse in-Charge mobile: 07713 071116. Both phone numbers will be answered 24 hours a day by a Registered Nurse who can advise on the referral immediately or plan a call back following discussion with the on-call Referral Panel Members within 12 hours.

Urgent enquiries or referrals can also be emailed to **noahs.nurses@nhs.net**. This inbox is checked daily by a Registered Nurse and a member of the Care Team will respond as soon as they are available within 24 hours.

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REFERRAL FORM FOR ALL CARE SERVICES

REFERRAL TYPE:

Routine ☐ **Urgent admission** ☐ **End of life** ☐ **Post death care** ☐ **Bereavement support** ☐

Noah's Ark Children's Hospice accepts children between the ages of 0-19 years based on the following criteria, in line with guidelines used by all Children's Hospices.

GROUP 1	Life threatening conditions for which curative treatment may fail e.g. cancer, irreversible organ failure.	☐
GROUP 2	Conditions where premature death is anticipated but intensive treatment may prolong life e.g. complicated cystic fibrosis, HIV.	☐
GROUP 3	Progressive conditions without curative treatment options where treatment is exclusively palliative e.g. Battens disease, mucopolysaccharidoses	☐
GROUP 4	Conditions causing severe neurological disability leading to susceptibility of health complications and likelihood of premature death e.g. severe cerebral palsy, multiple disabilities following brain or spinal cord insult. Group 4 children may need to undergo further assessment if eligibility is not clear using this criteria.	☐
GROUP 5	Current resident on Neonatal Intensive Care Unit, Specialist Maternity Services- Referral to Music Therapy Service.	☐
GROUP 6	Post Bereavement Support during the 3 year period following the death of a child.	☐

CHILD'S DETAILS

Child's Last Name: **Child's First Name:**

Child's date of birth: **Age:** **Male** **Female**

Child's ethnicity: **Religion:**

Family Address:

Postcode: **Tel No:**

Email:

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CONSENT TO REFERRAL AND TO SEEK & SHARE INFORMATION

For those unable to consent and children under 16:

I, the parent/guardian, give consent to the referral. Yes ☐ No ☐

For young people aged 16 years or above:

Does the young person have capacity to consent to the referral? Yes ☐ No ☐

If so, has consent been given to the referral? Yes ☐ No ☐

In order to provide safe and effective care, Noah's Ark Children's Hospice will need to obtain or share your child's up to date personal details, and general medical & social care information, including clinic letters, copies of prescriptions (FP10), emergency care plans and advance care plans from other professionals including (but not limited to) schools, community teams, GPs, hospitals, local authorities and/or clinical commissioning groups.

I, the parent/guardian, give permission for Noah's Ark Children's Hospice to seek & share health and social care information as outlined above. Yes ☐ No ☐

Please note that by making this referral it may be necessary for us to request further medical information as necessary.

MEDICAL DETAILS

Child's NHS Number: **Borough:**

Diagnosis:

Please specify all medical conditions and care needs:

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Date diagnosed (approximate):

Is the condition: Life threatening? ☐ Life limiting? ☐

Likely prognosis:

Current phase of illness – please check one box:

Stable ☐ Unstable ☐ Deteriorating ☐ Dying ☐ Unknown ☐ Deceased ☐

Please attach any relevant documentation such as a recent clinic letter to support the application.

ADVANCED PLANNING

Have any Advance Care planning discussions taken place? Yes ☐ No ☐

Please attach ACP or supply further details:

Is there a resuscitation/Respect document in place? Yes ☐ No ☐

Please attach. (If not, what discussions have taken place?)

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Is there a Symptom Management Plan? Yes ☐ No ☐
Please attach.

Please give a brief description of how you feel Noah's Ark can help the child and family referred. Please include any additional information you feel would be helpful with this referral.

Is there anything Noah's Ark need to be aware of before making contact with the child/family?

Who or what prompted you to make this referral?

IF THERE ARE SAFEGUARDING CONCERNS, PLEASE GIVE BRIEF OUTLINE:

Please tell us if the child subject to any of the following:

- ☐ Child Protection plan
- ☐ Care Order
- ☐ Special Guardianship Order
- ☐ Child in Need plan
- ☐ Child Arrangements Order
- ☐ Child in Care; by voluntary agreement (s.20)

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PLEASE DETAIL CURRENT CARE PACKAGE:

Social care:

Continuing healthcare:

Allocated social worker + Tel Number:

Community Matron:

Short breaks allocation

Care package hours; nights:

Overnights allocation:

Care package hours; nights:

Personal budget; Direct payments:

Personal health budget:

Has a continuing Care Assessment been completed in the last year?	Yes ☐	No ☐
Are the family accessing all of their package?	Yes ☐	No ☐
Any breakdown in the package?	Yes ☐	No ☐

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Which services at Noah's Ark do you think would help this child/family?

- ☐ Family Link (advocacy, emotional support, etc.)
- ☐ Family Days (days out for the whole family)
- ☐ Parent Groups (facilitated peer support for parents)
- ☐ Sibling Groups (activities for siblings aged 6-18 yrs.)
- ☐ Noah's Ark Children's Group (activities for the child being referred on this form)
- ☐ Home Support Volunteer (regular weekly visits for social, befriending or practical support)
- ☐ Specialist Care (short breaks in the community)
- ☐ Specialist Play (structured play - also offered to siblings)
- ☐ Therapies (Music, art or drama and movement sessions - also offered to siblings)
- ☐ Post Death Care at The Ark or in Community
- ☐ Bereavement Support 3 years

PROFESSIONAL'S DETAILS

Name of Professional	Role	Address	Tel No and Email
	☐ Main consultant ☐ Specialist		
	☐ Keyworker ☐ Social Worker		
	Health Visitor		
	Community Nursing Team		
	Therapist (SLT/ Occupational/Physio/ Play/Music/CAMHS)		

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GP DETAILS

GP Name	Name & Address of GP Surgery	Telephone No, Fax and Email

SCHOOL DETAILS

Contact Name & Position	Name & Address of School	Telephone No and Email

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PARENTS/CARER DETAILS

Last Name	First Name	Title	DOB	Relationship to child	Do they have parental responsibility?
					Yes ☐ No ☐
					Yes ☐ No ☐
Details of share care arrangements (if applicable)					

SIBLINGS DETAILS

Last Name	First Name	DOB	Sex
			Female ☐ Male ☐
			Female ☐ Male ☐
			Female ☐ Male ☐
			Female ☐ Male ☐
			Female ☐ Male ☐

What languages are spoken in the home?

Is an interpreter required? Yes ☐ No ☐

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REFERRER'S DETAILS

Full name: Role/Relationship to child:

Address:

Postcode Tel No:

Email:

Date of referral:

How did you hear about Noah's Ark?

- ☐ Already working in partnership
- ☐ Local professional networking
- ☐ Noah's Ark Presentation
- ☐ Noah's Ark Fundraising Event
- ☐ Family or Friend
- ☐ GOSH crèche/music therapy service
- ☐ Other, please state:

Please note that in order for us to process this referral the consent questions on the front page must be answered AND this form signed by both the referrer and parent/carer below.

Referrer's signature: Date:

Parent/Carer's signature: Date:

Please send the completed form to us by post, fax 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.

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