REFERRAL FORM

Hummingbird House (HH) welcomes referrals from any clinician involved in the care of a child or young person up to the age of 18 years who has palliative care needs. We provide holistic multidisciplinary care including input from specialist medical and nursing staff. HH's focus is on supporting individuals with life limiting conditions in whom death in the near future would not be unexpected, and those with significant comorbidities that will shorten life.

If the referral is for end of life care, for use of the end of life suite or you wish to discuss details before referring, please contact a member of the HH care team.

Date of Referral		Referral Taken By	
Reason for Referral		Is Child Known to Paediatric Palliative Care Service, LCCH?	

PERSONAL INFORMATION FOR CHILD (Mandatory for registering on Leecare)

Name Of Child		Address	
Date of Birth			
Gender	☐ Male ☐ Female		
Medicare Number		Private Health Care Fund	
Religion		Ethnicity	
Aboriginal or Torres Strait Islander	☐ No ☐ Yes	Interpreter required? Indicate which language	☐ No ☐ Yes

PRIMARY DIAGNOSIS AND COMORBIDITIES

Primary Diagnosis		Date of Diagnosis	
Please explain what factors of the current medical status has influenced the decision for referral and why it is felt that death in the near future would not be unexpected. Please indicate if any of the issues identified below are applicable and give relevant details.			
☐ Weight below 2nd centile		☐ Apnoeas	
☐ Oxygen dependent		☐ Non-invasive ventilation	
☐ Tracheostomy		☐ PICU admissions in past 2 years, reasons and duration	
☐ Gastrostomy, jejunostomy or nasogastric tube fed		☐ > 3 lower respiratory tract infections in the past year	
☐ Use of epilepsy rescue medication > 5 days a week on average		☐ GMFCS Level	
☐ Clearly deteriorating trend in all areas		☐ Other significant comorbidities	
Comments:			

PLEASE ATTACH RELEVANT DOCUMENTS

☐ Connected Care Plan	☐ Paediatric Acute Resuscitation Plan	☐ PPCS Patient Assessment Summary
☐ Respiratory Plan	☐ Seizure Management Plan	☐ Symptom Management Plan
☐ Behaviour Management Plan	☐ Other (please list)	

REFERRAL FORM

Name of Child:

FAMILY INFORMATION (Mandatory if family members are to be registered in HH's clinical record system)

Name of Carer 1		**Name of Carer 2**	
Parental Responsibility	☐ (please click)	Parental Responsibility	☐ (please click)
Custody order in place	☐ (please click)	Custody Order in place	☐ (please click)
Relationship to child		Relationship to child	
Date of Birth		Date of Birth	
First Language		First Language	
Interpreter required?	☐ No ☐ Yes	Interpreter required?	☐ No ☐ Yes
Aboriginal or Torres Strait Islander	☐ No ☐ Yes	Aboriginal or Torres Strait Islander	☐ No ☐ Yes
Ethnicity		Ethnicity	
Religion		Religion	
Address (if different from above)		Address (if different from above)	
Private Health Care Fund		Private Health Care Fund	
Home Phone No		Home Phone No	
Mobile Phone No		Mobile Phone No	
Email Address		Email Address	

AWARENESS OF REFERRAL & CONSENT

Are the parents aware of and consent to the referral	☐ Yes ☐ No	Is the child/young person aware of the referral?	☐ Yes ☐ No ☐ N/A due to capacity

REFERRER'S INFORMATION

Name of Referrer		Referrer's Telephone No	
Referrer's Address		Referrer's Email Address	
Referrer's relationship to the child/young person			

PROFESSIONAL INVOLVEMENT – MEDICAL

Lead Paediatrician		General Practitioner	
Practice Address		Practice Address	
Telephone No		Telephone No	
Fax No		Fax No	
Email Address		Email Address	
Aware of the referral?	☐ No ☐ Yes	Aware of the referral?	☐ No ☐ Yes

PLEASE EMAIL COMPLETED FORM TO

nurses@hummingbirdhouse.wmg.org.au

If you have any questions or need further information, please call 3621 4336.

Hummingbird House Staff:

Once referral has been received, please use the information gathering guide and contact the lead professional involved in the child's care. The child's main carer should also be contacted to introduce the family to Hummingbird House and to gain verbal consent for the referral to be processed.

REFERRAL FORM

The referral below is to be completed and signed by a medical practitioner or nurse practitioner involved in the primary care of the child being referred to Hummingbird House.

DATE OF REFERRAL: _____ / _____ / _____

TO: Hummingbird House Children's Hospice
60 Curwen Terrace
CHERMSIDE QLD 4032

Thank you for reviewing:

Child's name: _____

Date of birth: _____

This review relates to a multidisciplinary case conference and subsequent management of palliative care

treatment for _____

_____

This referral remains valid for ☐ 3 months ☐ 12 months ☐ an indefinite period.

Kind regards

_____

Signature

Practitioner Name: _____

Provider No: _____

Postal Address: _____

Phone: _____

Email: _____