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, or for care after a child or young person has died, or you wish to discuss details before referring, please contact a member of the HH care team.

Please ensure as many fields as possible are completed. Those indicated with an asterisk are mandatory.

Date of Referral*	Click here to enter a date	Referral Taken By	
Reason for Referral	Choose an item.	Is Child Known to Paediatric Palliative Care Service, QCH?*	Click here

PERSONAL INFORMATION FOR CHILD (Mandatory for registering on Patient Administration System)

Name Of Child*	[Child's Name]		Address*		
Date of Birth*					
Sex*	☐ Male ☐ Female				
Medicare Number*			Medicare Expiry Date*		M/C IRN*
Private Health Care Fund			NDIS Funding	☐ Yes ☐ No	
Ethnicity*			Religion*		
Aboriginal or Torres Strait Islander*	☐ Yes ☐ No		Interpreter required? Indicate which language	☐ Yes ☐ No	
Is the child under the guardianship of the Department of Child Services?*	☐ Yes ☐ No	If yes, please provide contact details of the child's case worker.	Name		Phone No
			Email Address		

PRIMARY DIAGNOSIS AND COMORBIDITIES

Primary Diagnosis*		Date of Diagnosis	Click here to enter a date

Please indicate 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.

☐ 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/week on average	☐ GMFCS Level Select Number
☐ Clearly deteriorating trend in all areas	☐ Other significant comorbidities

PLEASE ATTACH RELEVANT DOCUMENTS

☐ Specialist Clinic/Discharge Summary	☐ Paediatric Acute Resuscitation Plan	☐ PPCS Patient Assessment Summary
☐ Respiratory Plan	☐ Seizure Management Plan	☐ Symptom Management Plan
☐ Behaviour Management Plan	☐ Social Work and/or Family Handover	☐ Other (please list)

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Name of Child (please click in the field): [Child's Name]

FAMILY INFORMATION (Mandatory if family members are to be registered in Patient Administration 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?*	☐ Yes ☐ No	Interpreter required?*	☐ Yes ☐ No
Aboriginal or Torres Strait Islander*	☐ Yes ☐ No	Aboriginal or Torres Strait Islander*	☐ Yes ☐ No
Ethnicity*		Ethnicity	
Religion*		Religion	
Address* (if different from child)		Address* (if different from child)	
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 relationship to the child/young person*	
Referrer's Email Address*			

PROFESSIONAL INVOLVEMENT

Lead Paediatrician*		**General Practitioner***	
Practice Address		Practice Address	
Telephone No*		Telephone No*	
Email Address* Aware of the referral?	 ☐ Yes ☐ No	Email Address* Aware of the referral?	 ☐ Yes ☐ No
Social Worker*		To your knowledge, is there an existing bereavement in the immediate family network (eg partner, sibling, parent)?	☐ Yes ☐ No
Practice Address			If yes, please list:
Telephone No*			
Email Address*			

PLEASE EMAIL COMPLETED FORM TO

nurses@hummingbirdhouse.wmq.org.au

If you have any questions or need further information, please call 3621 4364.

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.

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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: **Click here to enter a date.**

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

Thank you for reviewing:

Child's name: **Click here to enter child's full name.**

Date of birth: **Click here to enter a date.**

This review relates to a multidisciplinary case conference and subsequent management of palliative care treatment for **Click here to enter child's main diagnosis.**

This referral remains valid for **Choose an item.**

Kind regards

_____ **Click here to enter a date.**

Signature

Practitioner Name:

Provider No:

Postal Address:

Phone:

Email: