London North West Healthcare NHS
NHS Trust

Children's Community Nursing Team
FAX TO : 0208 869 2533
Tel: 0208 869 3914

REFERRAL WILL NOT BE ACCEPTED WITHOUT FULL CONTACT DETAILS OF PROFESSIONAL REFERRING

Patient Sticker if available Name: Address: Postcode: DOB: Hospital Number:	Home Tel No: Mobile No: Paediatric Consultant: GP: Surgery: Tel: HV/School Nurse:
Diagnosis/ Reason for Referral:	
Next of Kin Name:	Parents aware of referral: YES ☐ NO ☐ Child fits criteria: YES ☐ NO ☐ Contact numbers Of CCNT given: YES ☐ NO ☐

Discharge Medication

Name Dose Duration

Allergies

Nursing input required ie IV's, wound care, **please include frequency of care required**

First visit Due: **End of Treatment Date:**

Language: Interpreter Required: Y / N	**Please supply minimum of 5/7 medicines and/or equipment or the referral cannot be accepted**
Discharging Professional Name: Designation: Contact Tel:	Signature:
Date Of Referral:	Referring Hospital/Ward Area:

DISCHARGING HOSPITAL CHECKLIST

Equipment/Medication Provided ☐ Discussed with Community Team ☐ Any Safeguarding Concerns ☐	**Harrow Community Children's Nurses Service Hours –** **MONDAY – FRIDAY 0800-1600:**