|  |
| --- |
| **Please ensure all 3 of the following apply otherwise the referral cannot be accepted:**   * 0-16 years old * Has an asthma diagnosis OR suspected asthma diagnosis and must be taking asthma **preventative** treatment * Has a Southampton City GP (Usually postcode SO14-SO19) |
| **The service can accept referrals for the following: Please tick all that apply** |
| Newly diagnosed asthma where there is a clinical need for specialist support  Support with Pharmacological/Non-Pharmacological asthma management  Support around asthma education  Continued/frequent asthma symptoms affecting quality of life  Visit/Repeated visits to unscheduled care (GP/OHH/ED) due to exacerbation of asthma  Repeated oral steroid courses required  Poor school attendance due to asthma |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Referrer Name/Job Role:** |  | | **Surgery/Service/Ward:** | |  | |
| **Referrer Contact No.:** |  | | **Date of Referral:** | |  | |
| **Patient Details** | | | | | | |
| **Patient’s Name:** |  | | **D.O.B:** | |  | |
| **NHS No:** |  | | **Gender:** | |  | |
| **Address:** |  | | | | | |
| **Parents/Main Carers** | | | | | | |
| **Name:** |  | **Relationship:** | |  | **Contact No.:** |  |
| **Name:** |  | **Relationship:** | |  | **Contact No.:** |  |
| **Spoken Language:** |  | | **Interpreter Required:** | | **Yes/No** | |
| **Any risks to visiting at home/lone working:** | Any known safeguarding concerns or safety issues: **Yes/No** (If yes, please give details) | | | | | |
| **Other Professionals Involved** | | | | | | |
| **Consultant:** |  | | **Nurse Specialist:** | |  | |
| **GP Name:**  **Practice Asthma Nurse:** |  | | **GP Surgery:** | |  | |
| **Health Visitor:** |  | | **School:** | |  | |
| **Social Worker:** |  | | **Other:** | |  | |
| **Clinical Information** | | | | | | |
| **Diagnosis:** |  | | **Allergies:** | |  | |
| **Current Medication:** |  | | **Relevant Past Medical History:** | |  | |
| **Child/Young person / Parents/Carers Aware of Referral:** | **Yes/No** | | **Any other relevant information:** | | | |

|  |
| --- |
| **If using SystmOne,** please send this form via electronic referral, selecting the followingTask Recipient:  **Asthma new eReferral** |
| **If not using SystmOne,** please send this form to:  [**childrenscommunityasthmawest@solent.nhs.uk**](mailto:childrenscommunityasthmawest@solent.nhs.uk) |
| For further advice, please contact us on: 0300 123 4153  **Service Address – Community Children’s Nursing, 2nd Floor, Adelaide Health Centre, William McLeod Way, Southampton, SO16 4XE** |