



# CHILDRENS REFERRAL FORM

## Aims of the James Hopkins Trust

- Free Respite nursing care in the family home or at our Respite Centre.
- Financial assistance for visit to specialist hospitals outside Gloucestershire
- Equipment specially designed for children with disabilities

To qualify for help from the James Hopkins Trust a child must be:

- Age 5 or under
- Living in Gloucestershire
- Have a **Life limiting** or **life threatening** condition with a **nursing need**
- or be **severely disabled** with a **nursing need**.

**PLEASE COMPLETE ALL SECTIONS CLEARLY IN PEN.**

Kites Corner, North Upton Lane, Barnwood Gloucester. GL4 3TR.

Tel: (01452) 632725 Fax: (08450788700)

nurses@jameshopkintrust.org.uk

Visit our web site at:- [www.jameshopkintrust.org.uk](http://www.jameshopkintrust.org.uk)

## **PERSONAL DETAILS**

### **CHILD'S DETAILS**

CHILDS SURNAME: .....

CHILDS FORENAMES: .....

DATE OF BIRTH: .....

ADDRESS.....

.....

.....POST CODE: .....

HOME TEL No: .....

MOBILE No's: .....

RELIGION: .....

NATIONALITY.....

MAIN LANGUAGE USED AT HOME IF NOT ENGLISH.....

### **NEXT OF KIN**

FATHERS NAME.....D.O.B.....

OCCUPATION: .....

MOTHERS NAME.....D.O.B.....

OCCUPATION.....

MARITAL STATUS.....

CONTACT TEL. No. (If different from above).....

BROTHERS/SISTERS NAME.....D.O.B.....

NAME.....D.O.B.....

## **MEDICAL DETAILS & MULTI-AGENCY SUPPORT**

GP's NAME, ADDRESS:.....

.....

.....POST CODE.....

TEL NO.....

CONSULTANT'S NAME.....

HOSPITAL.....

.....

.....POST CODE.....

TEL NO.....

**MEDICAL DETAILS & MULTI-AGENCY SUPPORT (Continued...)**

HEALTH VISITOR'S NAME, ADDRESS. ....  
.....

TEL No.....

SOCIAL WORKER'S NAME, ADDRESS .....

.....

..... TEL NO .....

COMMUNITY PAEDIATRIC NURSE NAME, ADDRESS. ....

..... TEL NO.....

OTHER SUPPORT WORKER'S NAME, ADDRESS: .....

.....

..... TEL NO.....

NAME OF NURSERY/ SCHOOL ATTENDED. & DAYS/ HOURS PER WEEK.....

.....

.....

**CHILD'S DIAGNOSIS**

PLEASE GIVE A DESCRIPTION OF THE CONDITION AND HOW THIS AFFECTS THE CHILD.  
GIVE DETAILS OF TREATMENT/NURSING CARE AND MEDICATION REQUIRED.

**MEDICATION BEING GIVEN:**

DRUG NAME	DOSE	FREQUENCY

PLEASE TICK IN THE BOX RELEVANT BOX BELOW WHO IS MAKING THE REFERRAL TO THE JAMES HOPKINS TRUST.

- GP
- CONSULTANT PAEDIATRICIAN
- PAEDIATRIC COMMUNITY NURSE
- HEALTH VISITOR
- SOCIAL WORKER
- PARENT
- RELATIVE
- OTHER (please explain)

Name.....

Signed.....

Date .....

If the referral is from a professional, it would be helpful if you could provide additional details separately i.e. the child’s diagnosis and current care and why you think they would be appropriate to received respite care from James Hopkins Trust. All information will be treated as strictly confidential.

**ARE YOU REQUESTING SUPPORT FOR**

(Please tick the appropriate box)

**USE OF KITES CORNER FACILITIES**

**RESPITE CARE IN THE FAMILY HOME**

Preferred times for respite:

Morning

Afternoon

Evening

ANY OTHER RELEVANT INFORMATION TO SUPPORT RESPITE REQUEST:-

**TRANSPORT COSTS TO SPECIALIST HOSPITALS**

(It is the policy of the Trust to have all bills and receipts Forwarded to the Trust office to enable correct accounting and distribution procedures)

**FINANCIAL ASSISTANCE FOR SPECIALIST EQUIPMENT**

(All equipment purchased for the applicant, will remain the property of the Trust, and must be returned when the child has no further use of it)

Please give full details of the equipment required with approximate cost.

HAVE YOU APPROACHED ANY OTHER AGENCY FOR SUPPORT (If yes, please give details)

ARE YOU IN RECEIPT OF ANY ALLOWANCES – e.g. disability living allowance, attendance allowance etc. (If yes, please give details)

**If you are a parent do we have your permission to contact your GP/Consultant Paediatrician/other professionals for further information in support of your application. If yes please sign & date below:-**

Signed.....

Date.....

**Applications Procedure**

- ◆ On receipt of this application, our Family Services Manager will arrange to make an assessment visit to your family home.
- ◆ Following this assessment the application will be considered by our Applications Committee.
- ◆ The Committee will have access to the information contained in this application form and any other relevant information.

I understand the procedure for processing applications and that the information given in my application form and other relevant information, will be made available to the Applications Committee.

Signed.....(parent/guardian) Print Name.....

Name of Child..... Date.....

**Please forward this Application to:  
The Family Services Manager,  
The James Hopkins Trust,  
Kites Corner,  
North Upton Lane,  
Barnwood  
Gloucester. GL4 3TR**

**If you have any questions regarding this Application Form or need assistance with filling it in please ring our Family Services Manager at our Trust Office on 01452 632725 or Fax us on 08450 788 700.**

*Details about the Trust can be found on our web site  
[www.jameshopkintrust.org.uk](http://www.jameshopkintrust.org.uk).*