



REFERRAL FORM

AIMS OF THE JAMES HOPKINS TRUST

- Free respite nursing care in the family home or at our Respite Centre.
- To assist financially with travel to out of county hospitals and contribute towards funding for specialist equipment.

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/medical need
- Severely disabled with a nursing/medical need.
- Every child and family will be assessed and allocated respite on an Individual basis.

PLEASE COMPLETE ALL SECTIONS CLEARLY IN PEN

Providing nursing respite care for children

KITES CORNER, NORTH UPTON LANE, GLOUCESTER GL4 3TR

☎ 01452 612216 www.jameshopkintrust.org.uk

 /thejameshopkintrust

James Hopkins Nurses Ltd is registered in Company House Cardiff Reg No.3610705
and registered with the CQC

PERSONAL DETAILS

CHILD'S DETAILS

SURNAME:

FORENAMES:

DATE OF BIRTH:

LIVES WITH:

ADDRESS:

POST CODE:

HOME TEL No:

MOBILE No's:

E-MAIL ADDRESS:

RELIGION:

NATIONALITY:

MAIN LANGUAGE USED AT HOME IF NOT ENGLISH:

NEXT OF KIN

FATHERS NAME:

AGE:

MOTHERS NAME:

AGE:

MARITAL STATUS:

SIGNIFICANT OTHER ADULTS:

PARENTAL RESPONSIBILITY:

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

SIBLINGS NAME:

D.O.B.:

NAME:

D.O.B.:



MULTI-AGENCY SUPPORT

GP's NAME, ADDRESS:

POST CODE:

TEL NO:

MAIN CONSULTANT'S NAME, HOSPITAL, ADDRESS:

POST CODE:

TEL NO:

HEALTH VISITOR'S NAME, ADDRESS:

POST CODE:

TEL NO:

SOCIAL WORKER'S NAME, ADDRESS:

POST CODE:

TEL NO:

COMMUNITY CHILDREN'S NURSE NAME, ADDRESS:

POST CODE:

TEL NO:

OTHER SUPPORT WORKER'S NAME, ADDRESS:

POST CODE:

TEL NO:

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

ARE YOU REQUESTING SUPPORT FOR (Please tick the appropriate box)

USE OF KITES CORNER FACILITIES

RESPITE CARE

OVERNIGHT RESPITE CARE AT KITES CORNER

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 TOWARDS 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.

ARE ANY OTHER AGENCIES INVOLVED IN THE CHILD'S CARE? (If yes, please give details)



REFERRAL COMPLETED BY PROFESSIONAL

Are the parents/carers aware of the referral being made to James Hopkins Trust?

Yes No

If parents not aware please give reasons why:

Name: _____ Signed: _____

Profession: _____ Date: _____

If the referral is from a professional, it would be helpful if you could provide additional details separately i.e. current clinic letter/ discharge summary. All information will be treated as strictly confidential.

REFERRAL COMPLETED BY PARENT / CARER:

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:

Name: _____ Signed: _____

Relationship to child: _____ Date: _____

APPLICATIONS PROCEDURE

- On receipt of this application, one of our Nursing Management Team members will arrange to make an assessment visit to your family home.
- Following this assessment the application will be considered by our Nursing Management Team.
- The Trust Management 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 Nursing Management team.

Signed: _____ (parent/guardian)

Print Name: _____

Name of Child: _____ Date: _____

Please forward this Application to:

Nursing Management Team, 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 Nursing Management Team 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.jameshopkinstrust.org.uk