|  |
| --- |
| **EVELINA LONDON CHILDREN’S HOSPITAL****Outpatient Paediatric CHRONIC PAIN SERVICE REFERRAL FORM** |
| **ACCEPTANCE CRITERIA CHECK LIST**Thank you for referring a young person in your care to the outpatient Paediatric Chronic Pain service. All referrals to the service need to be made using this proforma - accompanying letters and reports are welcome alongside. The referral information you provide is extremely important not only in enabling us to support young people and families living with pain, but also the professionals involved in their care. Therefore, please ensure all sections of the referral proforma are completed as incomplete forms cannot be accepted and will be returned to the referral source. **Note: Please complete ALL questions on this checklist to enable us to accept the referral.** |
| Is the child under the care of a local paediatrician, who will be responsible for ongoing management whilst the child/young person in receiving support at ELCH | Yes [ ]  No [ ]   |
| Is this referral being sent before the young person’s 17th birthday  | Yes [ ]  No [ ]   |
| Has the child/young person experienced symptoms for more than three months? | Yes ☐ No ☐  |
| Have you assessed this child/young person face-face | Yes [ ]  No [ ]  |
| Have you discussed/informed all professionals involved with the child/young person and family about this referral? | Yes [ ]  No [ ]  |
| Does pain get in the way of activities of daily living/ function?e.g. school, sleep, mobility, independent living, social relationships, family life | Yes [ ]  No [ ]  |
| Please give examples . . .  |
| Please provide the main reason(s) for the referral:Click or tap here to enter text. |
|

|  |  |
| --- | --- |
| Have any investigations been performed locally? Please attached any investigation results at the end of the form | Yes [ ]  No [ ]  N/A [ ]  |

 |
| **PATIENT DETAILS** |
| Child’s nameClick or tap here to enter text. | Date of birthClick or tap to enter a date. |
| AddressClick or tap here to enter text.Postcode: Click or tap here to enter text.  |  | Home phone: Click or tap here to enter text.Mobile phone: Click or tap here to enter text.Email address: Click or tap here to enter text. |
| NHS Number: Click or tap here to enter text. |
| Named Adult with Parental Responsibility: Click or tap here to enter text. |
| Relationship to Young Person? Click or tap here to enter text. |
| Has adult with PR consented to this referral? Yes [ ]  No [ ]  N/A [ ]  |
| Has the young person consented to this referral? Yes [ ]  No [ ]  N/A [ ]  |

|  |
| --- |
| **REFERRING CLINICIAN DETAILS** |
| NameClick or tap here to enter text.Telephone: Click or tap here to enter text.E-mail address: Click or tap here to enter text. | HospitalClick or tap here to enter text.Address:Click or tap here to enter text. |
| **Please list and provide contact details below of any current or previous professionals involved:** Including Physiotherapist, Occupational Therapist, Social Worker, Clinical Psychologist, Psychiatrist, school counsellor etc. |
| Name | Type of Professional and description of intervention/ support offered | Contact Details |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Is this patient known to any specialist medical teams, including mental health teams Yes [ ]  No [ ]  If yes, please provide details.Click or tap here to enter text. |
| Have you referred this patient to any other services e.g. other specialists, emotional wellbeing services, pain or therapy teams? Yes [ ]  No [ ]  If yes, please provide details.Click or tap here to enter text. |
| **MEDICAL HISTORY and EMOTIONAL WELLBEING** |
| Relevant Medical History including mental health and relevant current information: Click or tap here to enter text.Does this young person have acute or previous thoughts of self-harm? Yes [ ]  No [ ] Has this young person had thoughts of suicide, suicidal intent or attempted suicide in the past or currently? Yes [ ]  No [ ] If yes to any of the above, what safety plan has been put in place? Who is actively monitoring this with the young person and family?(please provide further information below) **note answering yes will not automatically warrant a rejection**  |
| **MEDICATION HISTORY** – any past or current medication |
| Click or tap here to enter text. |
| **FAMILY HISTORY** |
| Is there any family history of the following conditions? |
| Fibromyalgia/ Chronic Pain | Yes [ ]  No [ ]  | Chronic Fatigue | Yes [ ]  No [ ]  |
| Arthritis | Yes [ ]  No [ ]  | Other relevant Musculoskeletal Diagnoses | Yes [ ]  No [ ]  |
| Mental Health Conditions | Yes [ ]  No [ ]  | Any other relevant conditions | Yes [ ]  No [ ]  |
| Social Communication Difficulties | Yes [ ]  No [ ]  |  |  |
| Please provide details: |

|  |
| --- |
| **ANY CONCERNS AROUND LEARNING AND SOCIAL DEVELOPMENT?** **Please include social communication, ADL, education** |
| Click or tap here to enter text. |

|  |
| --- |
| **SCHOOL FACTORS**  |
| Name of School: | Year Group: |
| Does the child have any EHCP? Yes [ ]  No [ ]  | Is there SEND involvement? Yes [ ]  No [ ]  |
| Are there any difficulties with school attendance? Yes [ ]  No [ ]  If yes, please provide details.Click or tap here to enter text. |
| **SAFEGUARDING CONCERNS** |
| Are there any safeguarding issues? Yes [ ]  No [ ]  If yes, please provide relevant details, including family members and professionals involved.Click or tap here to enter text. |

|  |
| --- |
| **ANY ADDITIONAL INFORMATION that might be relevant to this referral** |
| Click or tap here to enter text. |

**Once completed, please send to outpatient Paediatric Chronic Pain Service, Evelina London Children’s Hospital, via**

* **EPIC InBasket:** 11712000102 ELCH PAED RHEUMATOLOGY (CHRONIC PAIN) REFERRALS
* **Save as a separate file and e-mail to**

**Gst-tr.ELCHRheumatologyReferrals@nhs.net**from a secure NHS.net account.

**Department Contact Details:**

**Post:** Evelina London Children’s Hospital, Paediatric Chronic Pain Service, Floor 3, Becket House, Westminster bridge road, London SE1 7EH

**Telephone:** 020 7188 7188,

* **Appointments ext:** 84000/ 58197, PaediatricAppointmentsRheumatology@gstt.nhs.uk
* **Secretary ext:** 58200/ 88479

**Clinical queries:** Gst-tr.EvelinaChronicPain@nhs.net