

LAURALYNN IRELAND'S CHILDREN'S HOSPICE REFERRAL FORM

CHILD INFORMATION

Child's Name _____ Known as _____

Child's Address
.....
.....

Eircode

Current location of care

Date of Birth _____ Gender _____

Nationality _____ PPS Number _____

Ethnicity _____ Religion _____

Main language _____ Interpreter required Yes No

Are there any Child Protection concerns with this child and family Yes No Unknown

Medical Card Yes No Please include No. if available



PARENTS / LEGAL GUARDIAN

Name		Name			
Relationship		Relationship			
Legal Guardian	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Legal Guardian	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Address	Tick the box if the address is the same as child's		Address	Tick the box if the address is the same as child's	
Otherwise, please include address and Eircode here			Otherwise, please include address and Eircode here		
<hr/> <hr/>			<hr/> <hr/>		
Home Phone No.		Home Phone No.			
Mobile		Mobile			
Email		Email			

REFERRER'S DETAILS

Name		Profession	
Email		Phone No.	

CONSENT AND AUTHORISATION OF REFERRAL

Please confirm you have spoken to this's child's legal guardians and that they give permission for this referral to proceed.

I have had a conversation with the people who are legal guardians for this child and confirm that they give permission for this referral to proceed. As part of that conversation, I have informed the parties that LauraLynn will make contact with them and that LauraLynn may seek further medical information from the referring clinician. LauraLynn will hold the data included in this form in line with Data Protection legislation.

Please confirm that the information included in this Referral Form is accurate.

I confirm that the information included by me in this Referral Form is accurate and up-to date.

Signature		Date	
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SIBLINGS/SIGNIFICANT FAMILY MEMBERS

Name	Male/Female	Age (if under 18)	Additional (health) needs
1			
2			
3			
4			
5			
6			

PROFESSIONAL INVOLVEMENT – HEALTHCARE PROFESSIONALS

e.g. Specialist Palliative Care Team, Clinical Nurse Co-ordinator for children with life-limiting conditions, Paediatrician, GP, Public Health Nurse, Social Worker, Physiotherapist.

Name	Title/Role	Phone	Email Address
1			
2			
3			
4			
5			
6			

ADDITIONAL SERVICES INVOLVED IN THE CARE OF CHILD AND FAMILY

e.g. Disability Service, School, Nursing Agency, Respite Services, Neurology Team, Respiratory Team

Service Name	Contact Person & Title	Phone	Email Address
1			
2			
3			
4			
5			
6			

PAEDIATRICIAN / LEAD CLINICIAN DETAILS

Name

Address
(Please include eircode)

Telephone Number

Email

GP DETAILS

Name

Address
(Please include eircode)

Telephone Number

Healthmail Address

SOCIAL CARE LEAD

Name

Address
(Please include eircode)

Telephone Number

Healthmail Address

MEDICAL DETAILS – TO BE COMPLETED BY PAEDIATRICIAN

Urgency of Referral

Routine

Soon

Urgent

For urgent referrals please contact LauraLynn CNS on 01 289 3151 or email referrals@lauralynn.ie

Diagnosis

PLEASE PROVIDE COPIES OF ANY ADDITIONAL INFORMATION/REPORTS THAT YOU FEEL MAY BE RELEVANT TO THIS REFERRAL

Brief Summary of Child's Current Condition and Description of Medical Needs:

.....

.....

.....

How would you assess this child's phase of illness at present?

Stable

Unstable

Deteriorating

End-of-life

Reason for Referral -

How do you think LauraLynn may best support this child and family? Please see <https://www.lauralynn.ie/what-we-do/childrens-palliative-care> for a description of available services.

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Please note, not all families will receive all aspects of the service offered by LauraLynn. Following acceptance to the service all families will have an holistic needs assessment completed to determine how to best meet their needs.

Does this Child/Young Person have a Life-Limiting Condition?

Yes

No

Comments:

.....

.....

.....

ACT Category
See Appendix 1

Category 1

Category 2

Category 3

Category 4

Category 5

Is this Child/Young Person expected to live beyond 18 years?

Comments:

.....

.....

.....

Estimation of prognosis

Days

Weeks

Months

Years

Has this been discussed with the child's parents?

Yes

No

Details of discussion:

.....

.....

.....

Has this been discussed with the child?

Yes No

Details of discussion:

.....
.....
.....

Does this child have an Emergency Care Plan?

Yes No

Comments:

.....
.....
.....

Please attach Emergency Care Plan +/- Ambulance Control Directive if available.

Does this child have a Symptom Management Plan?

Yes No

Please attach Symptom Management Plan if available

Is this child known to the Clinical Nurse Coordinator for Children with Life-limiting Conditions service

Yes No

Details:

.....
.....
.....

Is this child known to a Paediatric Palliative Care service or Specialist Palliative Care

Yes No

Details:

.....
.....
.....

PAEDIATRICIAN/CONSULTANT DETAILS

Name

Title/Speciality

Email

Phone No.

AUTHORISATION OF REFERRAL

Please confirm that the medical information included in this Referral Form is accurate.

I confirm that the information included by me in this Referral Form is accurate and up-to date.

Signature

Date

PALLIATIVE CARE NEEDS IN CHILDREN WITH COMPLEX NEURODISABILITY

When referring children with complex neuro-disability, the onus is on the referrer to demonstrate palliative care needs.

When referring children with neurodisability (in particular children with conditions in ACT category 4) please complete the following section which is a helpful guide to illustrate additional vulnerabilities.

Children in ACT category 4 may be physically dependent but stable. LauraLynn focuses on providing care to children and families most likely to benefit from all elements of the hospice service, including direct care, care, symptom management, family support, end of life care and bereavement care.

Please complete this and the following section with as much detail as possible. Failure to do so may result in a delay in the child and family accessing services.

Please include any recent medical or clinic reports.

Neuro-disability

Does the child have an inherited or metabolic condition causing severe neurodisability? Yes No

Or
Do they have severe acquired neurodisability? Yes No

Please complete the checklist below

Is the neurodisability associated with any of the following:

A vulnerable airway Yes No

Apnoeas requiring intervention Yes No

Scoliosis compromising respiratory function or causing severe pain Yes No

Frequent or prolonged hospitalisation, for example

1. 3 or more hospitalisations for severe illness over the past 6 months.
2. Hospitalisation of > 3 weeks without clinical improvement as determined by the clinical team
3. Admission to Paediatric Intensive Care or PICU for > 1 week

Details:

.....

.....

.....

.....

An ongoing need for oxygen therapy or ventilatory support Yes No

Escalating medical intervention
(This may include increasing dependence on medical technology, recurrent hospitalisations, or frequent symptom assessment)

Yes No

Details:

.....
.....

Gut failure / progressive feed intolerance

Yes No

Autonomic dysfunction or instability of brain stem function (temperature, circulation or breathing)

Yes No

Intrathecal baclofen pump

Yes No

Severe pain/discomfort without identified reversible cause

Yes No

Any other comments/details relating to the above please include here:

.....
.....

Seizure Disorder

Are seizures life-threatening? (Please note the risk of SUDEP is not sufficient to meet criteria.)

Yes No

Are seizures poorly controlled requiring frequent hospital admissions?

Yes No

Has the child been admitted to PICU due to poor seizure control?

Yes No

Is the seizure disorder progressive?

Yes No

Long-term Ventilation

Is this child under 5 years of age?

Yes No

Is this child over the age of 5 years with progressive respiratory failure?

Yes No

Behavioural Concerns

Does this child present with behaviours that can be challenging to manage?

Yes No

Please describe.

.....
.....

Note: Some children may present with highly complex and specialist nursing needs that may not be within the competency of LauraLynn to manage safely. Other children may present with behaviours that can be challenging to manage, may pose a risk to themselves and other children in the service and the environment of LauraLynn House may not be suitable for their needs and safe care.

System Failure

(Any organ failure leading to a life-threatening condition)

Organ failure awaiting transplant Yes No

Severe gut failure requiring TPN Yes No

Unstable cardiac condition awaiting surgery or not suitable for further cardiac surgery Yes No

Other

Deterioration in condition which highlights the life-limiting or threatening nature of diagnosis loss of independent mobility in boy with Duchene Muscular Dystrophy Progressive respiratory failure in child with Cystic Fibrosis: Yes No

PLEASE PROVIDE COPIES OF ANY ADDITIONAL INFORMATION/REPORTS THAT YOU FEEL MAY BE RELEVANT TO THIS REFERRAL

I confirm that the information included by me in this Referral Form is accurate and up-to date.

Name

Email

Phone No.

Signature

Date

Please complete and return to:

Referrals Panel

LauraLynn Ireland's Children's Hospice
Leopardstown Road, Foxrock, Dublin 18.

E referrals@lauralynn.ie

To speak to a CNS about a referral,
please call **01 289 3151**

Additional information:

LauraLynn's Referral Process
<https://www.lauralynn.ie/referral-process>

LauraLynn Children's Palliative Care
<https://www.lauralynn.ie/what-we-do/childrens-palliative-care>



LauraLynn
IRELAND'S CHILDREN'S HOSPICE

LauraLynn Ireland's Children's Hospice
Leopardstown Road, Foxrock, Dublin 18.

T 01 289 3151
E info@lauralynn.ie
www.lauralynn.ie

CHY 2633
CRN 20003289

APPENDIX 1: TOGETHER FOR SHORT LIVES

Categories of Life Limiting Conditions 2018

Category 1 Life-threatening conditions for which curative treatment may be feasible but can fail. Access to palliative care services may be necessary when treatment fails or during an acute crisis, irrespective of the duration of threat to life. On reaching long-term remission or following successful curative treatment there is no longer a need for palliative care services.

Examples: cancer, irreversible organ failures of heart, liver, kidney.

Category 2 Conditions where premature death is inevitable. There may be long periods of intensive treatment aimed at prolonging life and allowing participation in normal activities.

Examples: cystic fibrosis, Duchenne muscular dystrophy.

Category 3 3 Progressive conditions without curative treatment options. Treatment is exclusively palliative and may commonly extend over many years.

Examples: batten disease, mucopolysaccharidoses.

Category 4 Irreversible but non-progressive conditions causing severe disability, leading to susceptibility to health complications and likelihood of premature death. Examples: severe cerebral palsy, multiple disabilities such as following brain or spinal cord injury, complex health care needs, high risk of an unpredictable life-threatening event or episode.

Category 5 Unborn children with major health problems who may not live through birth, infants who may survive for only a few hours/days, infants with birth anomalies that may threaten vital functions, and infants for whom intensive care has been appropriately applied but developed an incurable diseases.
