Child/young person’s name: …………………………………………........................................................

Date of Birth: …………………………………………………………………........................................................

Diagnosis: ………………………………………………………………………........................................................

**Referrer’s Details:**

Name: …………………………………………………………………………………………………………………………………..

Relationship to child/young person: ……………………………………………………………………………………. Organisation: ..………………………………………………………………………………………………………………….…..

Telephone number: ……………………………………………………………………………………………………………...

Email: …………………………………………………………………………………………………………………………….……..

**THE FOLLOWING MUST BE COMPLETED AND SIGNED BY THE PERSON WITH**

**PARENTAL RESPONSIBILITY**

I, *(full name)* ………………………………………………………………………………………………………………..…

(relationship to child/ young person) ……………………………………………………………………………..

hereby consent to the child named above being referred to Jersey Hospice Care support services by the person named on this form.

In order for Jersey Hospice Care to undertake their initial assessment I authorise the sharing of information including my child’s name, date of birth and medical diagnosis.

I also give Jersey Hospice Care permission as part of the initial assessment to make contact with other professionals, as required, to gain information including (but not limited to) community nursing teams, GP, Paediatricians, Consultants from local or UK specialist hospitals, school/nursery.

|  |  |
| --- | --- |
| I, the parent/guardian, give permission for Jersey Hospice Care to seek & share health and social care information as outlined above. | **Yes / No** |

Signed: ………………………………………………………………………………………………………(Parent/Guardian)

Date: …………………………………………………

**Referral can not be processed in absence of a consenting signature**