

CHAS Referral Form



Children's Hospice Association Scotland
Sharing the Caring

This form should be used in conjunction with the CHAS referral procedure.

Child's Name _____

Address _____

Postcode _____

Date of Birth _____ **Sex** _____

Telephone Home _____ **Mobile** _____

Parents Name
Mother _____ **Father** _____

**Has the referral been discussed with the family
(and where appropriate with the child or young person)?** Yes/No

Date of Diagnosis _____

Diagnosis _____

Reason for referral _____

**Current medical
problems** _____

An opinion of prognosis and what has been discussed with the family

Current medications

Relevant family history

Key professionals involved in decision to refer:

Paediatrician

GP

Community Children's Nurse/Specialist Nurse

Social Work

Other

Other

Telephone:

Any other relevant information

Name _____ **Position** _____

Signed _____ **Date** _____

Tel No _____ **email** _____

Address _____

Postcode _____

Please send your completed form to the Director of Care at either hospice:

Libby Gold, Director of Care
Robin House
2 Boturich Road
Balloch
Alexandria G83 8LX

Sue Hogg, Director of Care
Rachel House
Avenue Road
Kinross
KY13 8FX

tel: 01389 722055
email: libbygold@chas.org.uk

tel: 01577 865777
email: suehogg@chas.org.uk