

**Horizon House Children's Hospice  
Referral Form**

<b>Name</b>		<b>Date of Birth</b>	<b>Sex M/F</b>	<b>Diagnosis</b>
<b>Address</b>		<b>Mother</b>		
<b>Postcode</b>		<b>Health History</b>		
<b>School</b>		<b>Father</b>		
<b>Religion</b>	<b>Parent's Marital Status</b>	<b>Health History</b>		
<b>Day</b>	<b>Telephone Numbers</b>		<b>Mobile</b>	
	<b>Night</b>			

<b>Sibling Name</b>	<b>Date of Birth</b>	<b>Health History</b>

**Professionals Involved/Community Support**

<b>Profession</b>	<b>Address</b>	<b>Telephone</b>
<i>GP</i>		
<i>Consultant</i>		
<i>HV</i>		
<i>Nurse</i>		
<i>SW</i>		
<b>Respite Services presently used</b>		

<b>Name, designation and contact number of person making referral</b>	<b>Are parents aware of referral?</b>	<b>District/Trust</b>
	Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Date of referral</b>

*Social/Medical and Nursing Information*

*Child's awareness of diagnosis (if appropriate)*

