

**Children and Young People’s Phlebotomy Services Referral Form**

**\* Starred fields are mandatory. If any of these fields are not completed the form will be returned.**

**Please send referral form to service via email to** **mft.manchesterccnt@nhs.net**

**Referral form must be completed in full, incomplete referrals will be returned.**

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| **\*Surname:** **\*Forename:****\*Previous Surname:** **\*Address:****Is a copy appointment letter required:** Yes / No**Please give details:**   | **\*Date of Birth**: **\*NHS Number:****\*Gender:** **\*Home Telephone:****Mobile Telephone:** **E-mail Address:** **Reminder required for appointments (if available):****Text:** Yes/No  |

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| **\*Language Spoken:** \***Religion:****\*Interpreter Required: \*Ethnicity:****Preference for interpreter: Male Female**  \***Access Needs:** (Please delete as appropriate )  |

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| **\*Early Help Assessment (EHA) Completed:** yes/no**Unique reference number (URN) :****Lead Professional:** **Name:** **Address:** **Telephone:** **Other Professionals Involved:**  | **\*GP Name:** **\*Practice Name:** **\*Practice Address:****Nursery / School Attended:**   |

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| **\*Diagnosis / Reason blood tests are required (please state which blood tests are required)** | **\*Additional information (Any factors needed to take into consideration such as social communication difficulties):** |
| **\*Please confirm the following:****Bloods requested in ICE as postponed****Yes/No****Prescription provided for local anaesthetic cream and 4x film dressings Yes/No** **Are any tests fasting or time specific Yes/No** | **\*Details of fasting/time specific tests** |

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| **Referrer Name:** **Designation:** **Address:**  **Telephone:**  | **Date of referral:**  **Has parent/guardian agreed to the referral?**   |

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| **Office Use Only -** Date referral received …………………….....…............... Demographic details checked on child health system? Yes / NoName……………………………………………….……….. Date……………………………………**Date of appointment**……………………………………… |