SOUTHAMPTON Children's Hospital

University Hospital Southampton NHS
NHS Foundation Trust

Southampton Children's Hospital Gastrostomy Referral

Child's Name: _____	**Referrer's name:** _____
DOB : _____	Designation : _____
NHS No.: _____	Address :
Address:	
	Email : _____
Phone (preferred): _____	Phone: _____
G.P & address:	

Reason for Referral (please include main diagnosis, co-morbidities, feeding issues):

Currently / previously tube fed? Select Detail:

Current weight: _____ (kg) Current location: Inpatient ☐ Outpatient ☐ *(tick as appropriate)*

Type of tube requested: *(select from drop-down list)*

Safeguarding issues? *(details)*

Current Health Professionals Involved:

Dietician – name and contact details *(if none, please state none)*

Children's Community Nurse – name and contact details *(if none, please state none)*

Notes to referrers:

1. Please complete this form electronically. To make referral via email please attach a saved copy of the completed form to an email and send to **pscns@uhs.nhs.uk** If you are not sending from an nhs.net email address please obtain parental permission to send via email since non nhs.net email addresses are not considered secure and personal details are being transmitted. To refer by fax (slower) please complete the form, print and then fax to Surgical secretaries on 023 8120 4750.
2. To refer by email please tick this box below to confirm you have parental consent ☐