**EPUT Children’s Asthma & Allergy Service**

***Referral Form***

**Please return by email to:** [**epunft.caa@nhs.net**](mailto:epunft.caa@nhs.net)

Telephone: 0344 257 3955

**Referrals that do not meet our criteria or are incomplete will be rejected**

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| **PATIENT DETAILS** | | | | | | | | | | | | | | | | | | |
| NHS Number | | |  | | | | | | | Surname | |  | | | | | | |
| First Name | |  | | | | | | | | | Date of Birth | | |  | | Gender |  | |
| Address |  | | | | | | | | | | | | | | | | | |
| Postcode | |  | | | | | | Contact Number | | | | |  | | | | | |
| Parent/Carer Full Names | | | |  | | | | | | | | | | | | | | |
| Parent/Carer Contact Number | | | | |  | | | | | | | | | | | | | |
| Has parent consented to referral | | | | | |  | | | Spoken Language | | | | |  | Interpreter required | | |  |
| Please list any safeguarding concerns | | | | | | |  | | | | | | | | | | | |

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| **PROFESSIONAL’S DETAILS** | | | |
| GP Surgery Name |  | | |
| Consultant Name |  | Hospital Number |  |

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| **REFERRER’S DETAILS** | | | | | | | | |
| Referee Name | |  | | Designation | |  | | |
| Hospital Name |  | | Contact Number | |  | | Date of referral |  |

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| **REASON FOR REFERRAL***(please tick accordingly)* | | | | | |
| **Asthma** (Complete Section 1) |  | **Allergies** (Complete Section 2) |  | **Eczema** (Complete Section 3) |  |
| **Reason for referral, History of symptoms and Current Medications** (Complete Section 4 **for ALL referrals**) | | | | |  |

**Asthma Referrals Exclusion Criteria**

1. No treatment commenced by GP.
2. Routine **controlled** asthma care.
3. **Asthma Care Plans for schools and nurseries (please contact universal services, i.e. GP, school nurse or practice nurse).**
4. Routine education on use of asthma devices - GP/Pharmacist/Nurse – should be able to do appropriate training or check online resources such as Asthma + Lung UK website [**https://www.asthmaandlung.org.uk/**](https://www.asthmaandlung.org.uk/)

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| **SECTION 1 – ASTHMA –** Referrals require at least one tick of points 3 to 7*(please tick* ***all*** *that apply)***:** | |
| 1. Aged **2** – 18 years |  |
| 1. Live within the SSO to SS9 postcode area |  |
| 1. Children with **uncontrolled asthma** on step 3 of MSE Pharmacological Formulary (children on step 4 should be referred to a Paediatric Consultant) to include the following symptoms: | |
| * nocturnal symptoms |  |
| * persistent cough and wheeze |  |
| * exertional symptoms |  |
| * an acute episode of exacerbation of symptoms requiring nebulisers or a course of oral steroids resulting in attendance at the Emergency Department (ED) |  |
| 1. Prescribed more than 6 short-acting Beta-agonists (SABAs) in the last 12 months in conjunction with **uncontrolled asthma** symptoms as per the list at point 1) above |  |
| 1. 2 or more courses of steroids over the last 12 months in conjunction with **uncontrolled asthma** symptoms as per the list at 1) above |  |
| 1. 2 or more A&E attendances for asthma within the last 12 months |  |
| 1. Admitted to hospital for asthma exacerbation |  |

**Allergy referral criteria**

1. It is the **responsibility** of the **referring clinician** to ensure copies of blood tests/skin prick tests are provided with the referral, so the team can provide allergy advice as appropriate.
2. This service provides adrenaline auto injector training for family members, child minders and nursery staff for children under the age of 5 years. We refer to School Nurses as appropriate.
3. For children and young people with multiple food allergies without an adrenaline auto injector - The service will support the family and provide supportive information to avoid allergens.
4. Liaise with the school nurse to assist with the development of care plans for school as required.
5. Children and young people should not be referred to the service for intolerances without immediate allergy to food groups.

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| **SECTION 2 – ALLERGY** – Referrals require at least one tick of points 3 to 5*(please tick* ***all*** *that apply)***:** | |
| 1. Aged **0** – 18 years |  |
| 1. Live within the SSO to SS9 postcode area |  |
| 1. Suspected immediate anaphylactic reaction (e.g. hives, angioedema, anaphylaxis) and has been prescribed an adrenaline auto injector |  |
| 1. Allergies have been confirmed by IgE bloods or skin prick testing |  |
| 1. Experiencing allergy related reaction symptoms for more than 3 weeks to include: | |
| * offensive stools |  |
| * diarrhoea/constipation |  |
| * eczema/skin related irritation |  |
| * abdominal pain |  |
| * PR bleeding |  |
| * nasal rhinitis |  |
| * orbital symptoms to include redness, swelling, watery clear discharge |  |
| * persistent cough during pollen seasons |  |
| * faltering growth |  |
| * gastro oesophageal reflux |  |
| * family atopic history |  |

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| **SECTION 3 – ECZEMA** – Referrals require at least one tick of points 3 to 4*(please tick* ***all*** *that apply)***:** | |
| 1. Aged **0** – 18 years |  |
| 1. Live within the SSO to SS9 postcode area |  |
| 1. Started treatment/creams but are still symptomatic |  |
| 1. Previously required steroid treatments |  |

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| **SECTION 4 – REASON FOR REFERRAL, HISTORY OF SYMPTOMS & CURRENT MEDICATIONS** | |
| Give details for referral | |
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| History of symptoms | |
|  | |
| Current Medications | |
| Asthma Reliever |  |
| Asthma Preventer & Dose |  |
| Allergy Medications |  |
| Eczema Medications |  |