**Primary Care Paediatric Rapid Access Clinic Referral Form**

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| Patient Demographics |
| Name |  |
| Date of Birth*Please note children are only eligible before their 16th birthday* |  |
| NHS number |  |
| Address |  |
| Contact telephone number***Please ensure both numbers are current*** | Landline |  |
| Mobile |  |
| Referrer information |
| Name |  |
| GP practice |  |
| Contact telephone number |  |
| Referral Information |
| Date of referral |  |
| Has this patient already been seen in the paediatric service with this problem? |  |
| Reason for referral |  |
| Summary of referral: |
| Is an interpreter required? | Yes | Which language: |
| No |  |
| I would like this patient to be seen within | 2 working days |  |
| 2 weeks of referral |  |
| I confirm that I have advised the parent/guardian to expect a telephone call advising them about the time and data of their appointment.  |  |

*Affix patient Label*

To be completed by clinic team on receipt of referral:

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| Referral receipt |
| Date & time of referral |  |

To be completed by triaging consultant:

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| Consultant Triaging |
| Date of Triaging |  |
| Decision regarding timing | To be seen within 2 working days |  |
| To be seen within 2 weeks |  |
| Can be seen in routine clinic |  |
| Needs to be seen on CAU |  |
| Requires further information |  |
| Not appropriate for paediatric service*If referral rejected, consultant to phone GP or dictate letter* |  |
| Comments |
|  |
| Appointment made |
| Date & time of appointment |  |
| Parent/guardian informed of the appointment |  |