Children's Complex Care Brokerage Referral Form

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| CYP & Organisational Details |
| Patient Initials  |  | Year of Birth:  |  | Gender |   |
|  Post code: |  |
| Person making the Referral/including contact details:  |  |
| Email request to:  | ChildrensComplexCare@portsmouthcc.gov.uk |
| Telephone Number:  |  0744326 7361 |
| Host LA/ICB: | Portsmouth City Council and/or HIOW ICB  |
| Date of Referral: |   |
| Required Start Date of Package: |  |

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| **Place service user is presently supported** | Home / Hospital / Care Home / Hospice |

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| **Package Requirements** |
| **Staffing Requirement:** | **e.g. carer/ trained nurse/ LDA experience/male or female preferred** |
| **Staffing ratio:** |  **1:1 or 2:1 (any step down plan)** |
| **Total Hours per week:** | **Term time:****School holidays:** |
| **Night Hours:** |  |
| **Day Hours:** |  |

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| **Pen Picture Summary** |
| ***Please use anonymised information from assessments/care plans/ decision support tool (DST)/ resource panel/ HSNP referral information relevant to CYP requiring care package and family set up*** |

**For complex care team only**

Date request received by Complex care Team:

Date actioned:

Response sent to CSC:

Date package confirmed by CSC, name and title:

Mileage cap (if required)

Expenses agreed date and by whom:

Contract signed by both parties (if commissioned off framework):