

GP Referral Form

Child's name:		CHIE checked Yes/No
Date of birth:	Age:	Male/Female
NHS number:	Hospital number:	Weight:
Address:		Parent/Carers name:
Post code:		Contact number:
Referral Date and Time:	Referred by:	
CHAT call within 2 hours (KPI)*		
GP Practice:		
Diagnosis:		
Background:		
Situation:		
Covid test done Yes/ No	Result:	Smoker in the household Yes/ No
Airway & Breathing	Circulation	Disability
Respiratory rate:	Heart rate:	Alert:
Recession:	Capillary refill:	BM if gastroenteritis:
Oxygen Saturations:	Fluids	Urine dipped/Requested
Temperature:	Fluid routine:	Result:
Rash:	Weight:	
Recommendations (Plan)	Treatment commenced	
Last Inhaler if applicable:	Oral antibiotics	
	Prednisolone/ Dex	
	Dioralyte	
Any safeguarding issues? E.g Domestic violence, Drug/ alcohol misuse Yes/ No		
Is the child subject to a child protection plan? Yes/ No		
Does the parent have any learning disabilities/ language barriers? Yes/ No		
Are there any risks to visiting professionals? Yes/ No		
If CHAT wasn't available would you have referred to paediatrics? Yes/ No		