



CED Referral to Acute Children's Outreach Nursing Service

1. DETAILS

Name:		DoB:		ID no:		Weight:	
Parent best CONTACT no * please check with parent*							
Referral Diagnosis:	ACORNS Care Plan:						

2. PLEASE COMPLETE and REFER TO ACORNS at 2-3hrs & enter on Symphony Referrals Column

Have ALL current referral criteria (March 2020) been achieved? (please tick boxes)	Yes	No	ACORNS use
Do ACORNS have capacity for new patient?			
Have a defined illness as per current Referral Criteria (March 2020)?			
Reviewed and agreed as suitable for Nursing assessment by senior Dr/ANP/Nurse Consultant/APNP.			
PEWS = 0-1 max on discharge ? Please repeat obs prior to referral			
Safe to manage at home for > 2hrs prior to first ACORNS phone contact?			
Is this child currently an inpatient in SSU?			
If 'Yes', has the discharge summary been completed?			
Suitable for telephone / video assessment/ or Home Visit if resident of Brighton & Hove?			
Parental consent for ACORNS referral?			
Is parent wishing to leave the ward against best medical advice			
New Safeguarding concerns. <i>If CPP already in place please ensure documented WHY in CED/SSU/ward notes.</i>			
3. MUST BE Completed Before Discharge	Yes	No	
** Have you checked Parent / Carer details ADDRESS & PHONE **			
ACORNS info leaflet given to parents?			
Written 'ALEX' condition or other written safety net advice given to parents?			
Attach referral form to notes and put in 'ACORNS' tray or give to ACORNS Nurse			

Time Frame for first ACORNS contact by phone	2 -4 hrs	>4hrs	tomorrow
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4. Referral to ACORNS

<i>Name & Signature of Referring Senior Doctor Consultant/ ST4/ Nurse Consultant and APNP:</i>	
<i>Referred to ACORNS date and time:</i>	
Additional Notes:	
Referral accepted and signed by ACORNS nurse	date & time: