*A/E Return ufo to Leake

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PAEDIATRIC REFERRAL FORM

DATE 17/03/98 NAME OF CHILD SIMON GARNETT	D.O.B. 26/04/81 AGE: MALE/FEMALE (Please circle)
ADDRESS 6/N Greenlanes N8 9RE TELEPHONE	G.P. TELEPHONE:
WARD Date of Admission	CONSULTANT
N.O.K	NAME OF MOTHER/FATHER/GUARDIAN
Are there any siblings? Names and Ages	Please specify
SCHOOL:	ETHNICITY
Is an Interpreter needed? No ☐ Yes ☐	Which Language?

WHAT IS THE REASON FOR REFERRAL?
What is the reason for admission to hospital?

Assault. Several wounds A/E Contact.
(Refer to S/S)

NAME OF REFERRER	Is the child known to Social Services? Yes No Unknown (please circle)

IS THE CHILD ON THE CP REGISTER?
YES ☐ NO ☐ UNKNOWN ☐ (please tick)

If there are CP concerns - have they been discussed with parents? Please specify name of Paediatrician

Have the CP forms been completed? Yes No

WHICH BOROUGH DOES THIS CHILD RESIDE IN?

ENFIELD ☐
HARINGEY ☐

OTHER - PLEASE SPECIFY _____