Here for families of
seriously-ill children. Always.

Sebastian's Action Trust Referral Form

Once we have received your referral form we will contact you to confirm receipt. The second phase of the referral will involve us making contact with your Consultant/CCN (if applicable) to confirm your child meets the below criteria:

Our criteria for taking on new referrals are that the child must have a life-shortening condition according to NICE Guidelines:

Group 1 – Life threatening conditions for which curative treatment may be feasible but can fail. (E.g. cancer, irreversible organ failures of heart, liver, kidneys.)

Group 2 – Conditions where premature death is inevitable. (E.g. cystic fibrosis)

Group 3 – Progressive conditions without curative treatment options. (E.g. Batten disease, mucopolysaccaridoses, muscular dystrophy.)

Group 4 – Irreversible but non-progressive conditions causing severe disability leading to susceptibility to health complications and likelihood of premature death. (e.g. multiple disabilities such as brain or spinal cord insult.)

Child's full name		
Child's date of birth		
Gender	Male	Female
NHS Number		
Child's School		
Home Address		
County		
Postcode		
Mum's Name		
Occupation		
Contact number		
Email Address		
Dad's Name		
Occupation		
Contact Number		
Email Address		

Sebastian's Action Trust
The Woodlands, Upper Broadmoor Road, Crowthorne, RG45 7FN
Tel: 01344 622500 info@sebastiansactiontrust.org www.sebastiansactiontrust.org
Registered Charity (No.: 1151146) & Company Limited by Guarantee (No.: 8339436)

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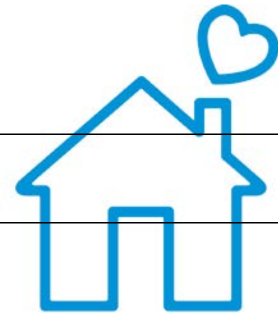

Contact in case of emergency	**Name:** **Number:**
Child's Condition	
Being treated at	
Consultant Name and Contact details	**Name:** **Telephone:** **E-mail:**
CCN (Children's Community Nurse)	**Name:** **Telephone:** **E-mail:**
Social Worker (if applicable)	**Name:** **Telephone:** **E-mail:**
Key Worker (if relevant)	**Name:** **Telephone:** **E-mail:**

I give/do not give permission for my consultant/GP/CCN to confirm my child's medical condition

Signed: ....

Siblings	
Name and Date of Birth	
Name and Date of Birth	
Name and Date of Birth	
Name and Date of Birth	

Please indicate below a maximum of five services that you feel would offer the most support your family at this time (after 6 months of support this can be reviewed to best meet your families needs):

Other Services

Emotional support through 1 – 1, drop in or group sessions	
Child Support Worker – individualised activities adapted to the child's needs	
Volunteer Befriending Service	

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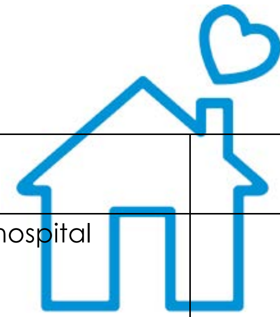

Siblings support – individual activities	
Hospital visits – accompany or to spend time with a child at home or hospital	
Advocacy with meetings involving other healthcare professionals	
Financial assistance, debt management, grant applications, form completions	
Practical support at home/shopping	
Programme of events - meeting others in similar situations	
Access to Bluebells pool and day visits	

Please detail any other organisations/support services your family is accessing. This will help us work collaboratively with your support network to provide the best care for your family:

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Signed: ……………………………………………………………………………………

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