# ***BCG Referral Assessment Form for 0-15 year old children***

Please complete the following questions

Office phone number 0300 555 5055

**Child’s details**

Name: Date of birth:

NHS No:

Parent/Guardian/s name(s):  
Address:  
Contact number:

GP name & practice:

Hospital of birth:

School:

**Referrer’s details**

Referrers name: Designation:

Referrers address:

Referrers NHS email: Referrers contact number:

Referral date:

**Clinical information**

**(Please answer all questions, incomplete referrals may be sent back to referrer)**

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| --- | --- |
| Has the **child** received a BCG vaccination? (Please ensure the Child Health Record has been checked) |  |
| Was the **child** born in the UK? |  |
| If **NO,** please state country of birth: |  |
| Were the **child’s parents** born in the UK? |  |
| If **NO,** please state country/countries of birth: |  |
| Were all the child’s **grandparents** born in the UK? |  |
| If **NO,** please state country/countries of birth: |  |
| Has the **child** lived or stayed in a country other than the UK for longer than 3 months? |  |
| If **YES,** please state the country and for how long: |  |
| **Clinical information continued** |  |
| Was the child born before 28 weeks gestation? |  |
| If **YES,** what gestation and were there any complications? |  |
| Does the child have any medical conditions? |  |
| If **YES,** please state conditions: |  |
| Is the child on any medication? |  |
| If **YES,** please state medication: |  |
| Did the child’s mother have COVID during pregnancy? |  |
| If **YES,** was she hospitalised? |  |
| Was/is the child’s mother taking immunosuppressants/ high dose steroids or chemotherapy medication during pregnancy or whilst breastfeeding? |  |
| If **YES,** please state medication: |  |
| Is the mother HIV positive? |  |
| If **YES,** has the HIV PCR blood test results returned as negative prior to BCG? |  |
| Has the child had a close contact with anyone in the household with Active TB? |  |
| Has the child been screened for SCID? |  |
| If **YES**, please state result:  SCID Not Suspected  SCID Not tested/Offered  SCID Detected |  |
| Is the child known to Social Services? |  |
| If **YES,** who has parental responsibility for the child?  Please state name and relationship to the child: |  |
| Any other relevant information? |  |
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