Request for BCG Vaccination

Babies under 12 months born in Mid Yorkshire Trust should be referred back to Mid Yorkshire Maternity Services where they will receive the BCG vaccination.
The contact number is- **01924 512178.**

Children who move into the catchment area for Mid Yorkshire NHS Trust CCG under 12 months of age who are identified as eligible for BCG vaccine and who have not yet received their vaccination will need a direct referral from the GP / HV to the specialist TB nursing team to be vaccinated. Community TB service contact number**-03033309869**

They do not require a referral to the Mid Yorkshire Paediatric Outpatient BCG clinics.

Please follow the flow chart overleaf before completing the request for BCG vaccination. If incomplete forms are submitted, they will be returned to the referrer to be completed fully.

Name of Child ....DOB...............................NHS Number...
Address .... Telephone ....
....
.... Place of Birth..
(Name and Address of Hospital)
Mothers Name.. Mothers NHS No...................................
Confirmed parents wish BCG Vaccination to be requested ☐ (please tick if confirmed)

Criteria for BCG Vaccination (please tick)

☐ 1. The child was born in a country where the annual incidence of Tuberculosis (TB) is 40/100,000 population or greater. Name of Country ....

☐ 2. The child's Parent or Grandparent was born in a country where the annual incidence of TB is 40/100,000 population or greater. Name of Country..

☐ 3. Confirmed family history of TB in the past 5 years. Name of person who had TB/Year/Address..................
....

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Checklist

Launch SCID result if applicable ☐

Check mother was not treated with any immunosuppressant during pregnancy ☐

Checked system 1 and no record of BCG given ☐

Check parent held record and no record of BCG seen ☐

Checked child for BCG scar and scar not seen ☐

Details of any pre-existing medical conditions and treatment
....
....
....
Name and location of any Consultant involved in care of child..
....

No HIV risk identified from birth records or child's records ☐ date checked...........

(e.g., Maternal HIV status negative) Please tick and date to indicate no risk identified)

Name and designation of person legally able to provide consent...Mother/Father/Other

If this is not the parent then please provide the name /address/designation of the person with legal parental responsibility for child. Please remember if the child is a looked after child with shared parental responsibility with parent and Local authority and natural mothers' consent is being overridden in the best interest of the child this should be stated and a copy of the legal order sent with the referral.

Name..
Designation...
Address...
....
....
Telephone ....

Statement of why parental consent is being overridden
....
....
....
Signature

Name of Referrer...Designation ....
Contact Telephone ....Signature ....

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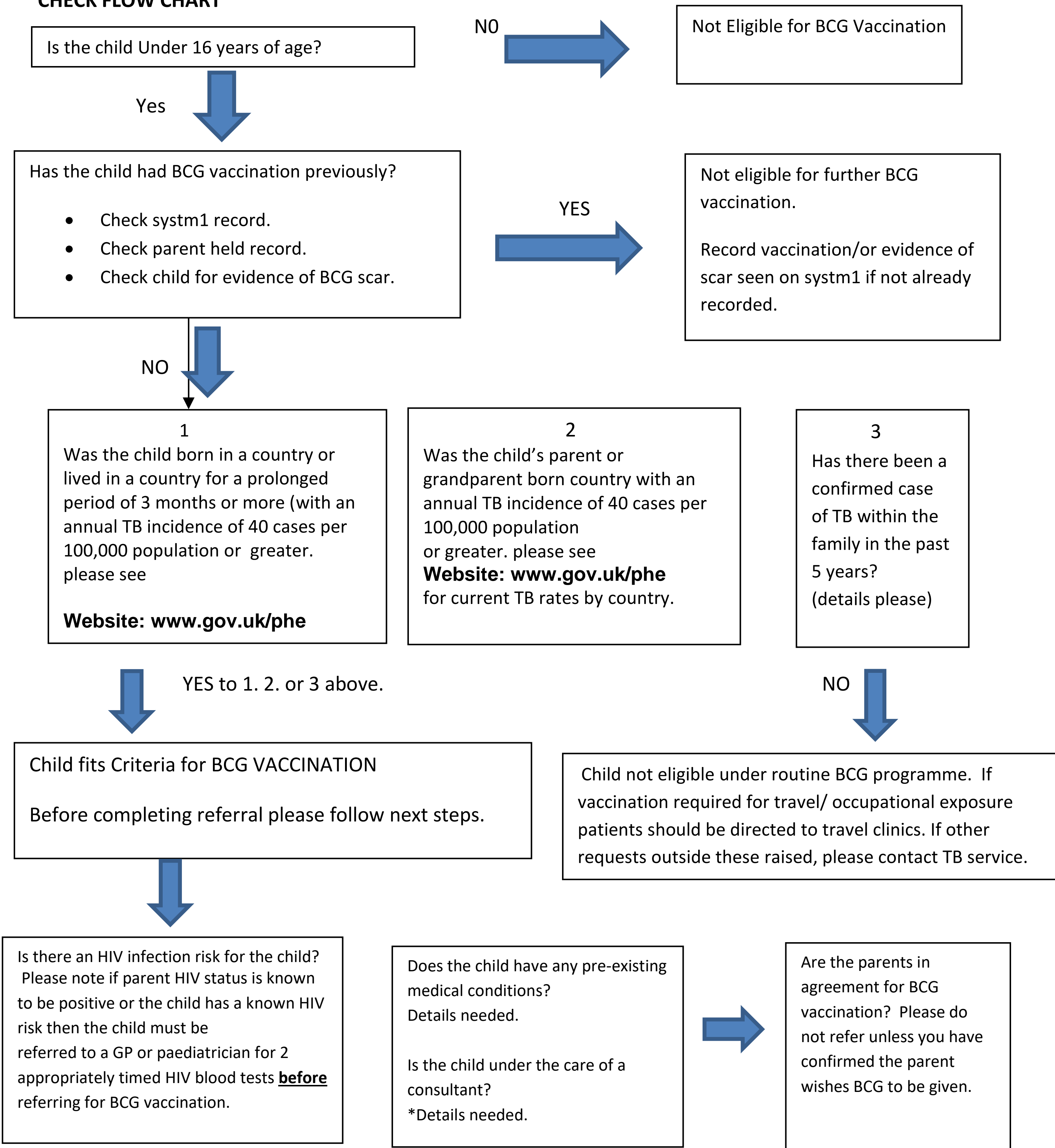

You will need the name of the person legally able to provide consent and further details will be needed if the child is a looked after child with shared parental responsibility between natural parents and the Local Authority. All attempts to gain consent of natural parents who retain parental responsibility should be made. I f this consent cannot be obtained then the local authority officer with parental responsibility may override the natural parent s consent in the best interests of the child. This will need to be stated on the referral and a copy of the legal order attached.

PLEASE FULLY COMPLETE THE REFERRAL FORM AND FORWARD EMAIL TO
LCP.kirkleestbservice@locala-cic.nhs.uk