

Young Adults Team,

Unit 3/4 St. John’s Court,

St. John’s Grove, Johnstown,

Co. Kildare W91 YO74.

E: yatadmin@kare.ie

T: 087 682 4240

**Young Adults Team Referral form**

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| **Criteria for the Young Adults Team*** Young adult has left school and is aged 18 - 26 years of age inclusive.
* Young adult lives or attends a day service in DSKWW.
* Young adult presents with complex developmental disability related needs, which requires support from 2 or more disciplines on the team, and whose needs would not be more appropriately addressed within the framework of a Primary Care or Mental health Service.
* The day service the young adult attends or is due to attend, does not have provision of multi-disciplinary support as part of their service level agreement. Where a day service has discipline specific clinical support available, this should be exhausted prior to a referral to the Young Adults Team.

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| Please tick to indicate that the young adult meets the criteria for referral as described above: |  |

Before submitting the referral, please ensure the following:* There is a clear reason for the referral, and you have specified what you hope the outcome of the referral will be.
* Contact details for the person making the referral.
* You have all the supporting documentation to send with the referral. We require a copy of the most up to date psychological report, any diagnostic reports, a discharge summary report if they were previously linked with a clinical team, most recent OT, SLT, Physio, Social Work reports and any relevant support plans such as a communication support plan, a positive behaviour support plan.
* You have asked the young adult’s consent prior to sending the referral. See separate consent document which must be sent in with the referral form.

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| **Date of Referral**  |  | **Referrer name** |  |
| **Referrer Occupation**  |  | **Referrer email and contact phone number** |  |

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| **(A)YOUNG ADULT’S PERSONAL DETAILS** |
| **Surname** | **First Name** |
| **Year young adult left school** | **Date of Birth** |
| **Address****Eircode** |
| **Family contact phone number** | **Young Adult’s contact phone number** |
| **Family Email address** | **Young Adult’s email address** |
| **Country of Birth** | **First Language:****Other languages spoken at home?** | **Interpreter required?****Yes No** |
| **Considering the referral is for the Young Adult for support, they should be contacted first for consent to engage in working with the YAT.** **Please outline the best way to contact the person to begin work.** |
| **(B) REASONS FOR REFERRAL** |
| **What are the main concerns and priorities for the young adult and their family?** **What would the young adult like support with?**  | 1.2.3. |
| **Are there any supports/strategies already in place to support this identified need?****Please detail.** |  |
| **What outcomes do you hope to get from submitting this referral form?** |  |
| **Are other information/risk factors related to this referral.** |  |
| **If the young adult has been referred to the YAT before, and there are no changes to any of the below information, you do not need to complete sections C, D, E and F.** **Please ensure that the consent form is completed, and all relevant reports included. We will not accept a referral without consent from the young adult and copies of relevant reports/plans.** |
| **(C) PREVIOUS CLINICAL SUPPORTS** |
| **Has the Young Adult previously attended the Children’s Network Disability team or other school age clinical teams?****Please provide details of team** | **Have they attended Primary Care teams?****Speech & Language Therapy** **Occupational Therapy** **Physiotherapy****Psychology****Other (please give details)** |
| **Mental Health Service** | **Tusla**  |
|  **Name of School Attended:** **Contact details of school:****School Principal:****Name of school personnel with most knowledge / experience with the young adult:** |
| **(D) DAY SERVICE DETAILS** |
| **Day Service Organisation** | **Keyworker Contact Name** |
| **Specific Day service Location/Address** | **Key Worker phone number/email** |
| **Manager/Contact Person of Day Service** | **Manager phone number/email address** |
| **(E) MEDICAL HISTORY (Attach any relevant Medical Reports)** |
| **GP name and contact details** | **Relevant Medical History/Surgical Intervention** |
| **Allergies/Adverse medication events** | **Current investigations e.g. blood tests, scans, hearing tests** |
| **Neurodiversity/Diagnosis** Has the young adult received any professional diagnoses indicating an Intellectual Disability, Autism, Sensory Impairment, or others? Please Describe and attach relevant reports. |
| **(F) SOCIAL CIRCUMSTANCES** |
| **Relevant family and social history**For example, family health or housing difficulties, financial or employment problems, bereavement, or other stresses |
| Please identify the strengths / interests and capacities that would be helpful for the team to be aware of when working collaboratively with this young adult, their family and service provider: |
| **Please email your referral with all the supporting documentation including*** **Most up to date psychological report, even if this is quite old.**
* **Discharge summary report if young adult was linked with a CDNT/clinical team.**
* **Any other relevant clinical reports from recent involvement with OT/SLT/Physio/Social Work.**
* **Any relevant support plans e.g., behaviour support plan/communication support plan**

**Please email a completed referral form to:** **yatadmin@kare.ie****You can also post referral form to:** **Young Adults Team,****Unit 3/4 St Johns Court,****St Johns Grove,****Johnstown,****Co. Kildare****W91Yo74****If you would like to discuss this referral with a member of the team, you can contact** **yatadmin@kare.ie** **or you can contact the Young Adults Team on 087-6824240** |