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Description automatically generated **Young Adult’s team Referral form**  A picture containing text

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| --- | --- | --- | --- | --- | --- |
| **Criteria for the Young Adults team,**   * Individual is 18 years of age. * Individual lives within CH07 area or attends a day service in CHO7. * The young adult has left school within the previous 3 years, or 5 years where the capacity of the team allows. * Evidence must be provided through accompanying reports that the individual presents with “complex needs” which significantly impacts on their physical, social, emotional, communication and/or behavioural domains. The individual’s level of disability requires the support from a multi-disciplinary team and their needs cannot be met within the framework of a primary care team. * The individual is not accessing supports from another clinical team, or if they are in receipt of clinical supports, they are due to be discharged e.g., CDNT   Please tick to indicate that the young person meets criteria for referral as described above: Tick box here  **Date of Referral Referrer name:**  **Referrer Occupation Referrer Contact details:** | | | | | |
| **(A)YOUNG ADULT’S PERSONAL DETAILS** | | | | | |
| **Surname** | | | **First Name** | | |
| **Gender** | | | **Date of Birth** | | |
| **Address:**  **Eircode:** | | | | | |
| **Family contact phone number** | | | **Young Adult contact phone number** | | |
| **Family Email address:** | | | **Young Adult email address:** | | |
| **Country of Birth** | | **First Language**  **Other languages spoken at home** | | | **Interpreter required.**  **Yes No** |
|  | | | | | |
| **(B) REASONS FOR REFERRAL** | | | | | |
| **What are the main concerns and priorities for the young adult and their family?**  **What would the young person 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 person 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** | | |
| **Other (Please give details)**  **Name of School Attended:**  **Contact details of school:**  **Year School Completed/due to complete:**  **School Principal:**  **Name of school personnel with most knowledge / experience with the young person:** | | | | | |
|  | | | | | |
| **(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 person 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 | | | | | |
| **ANY OTHER RELEVANT INFORMATION** | | | | | |
| Please identify the strengths / interests and capacities that would be helpful for the team to be aware of when working collaboratively with this young person, their family and service provider: | | | | | |
|  | | | | | |
| **Please email your referral with each of the listed documents below.**  **Competed YAT referral and signed consent from the young person.**  **Copy of the young person’s Person-centred plan.**  **Copies of all relevant professional reports including any other relevant support plans that may support this referral e.g. PBS plan/FEDS report/Communication support plan.**  **Please email a completed referral form to** [**referrals.dosmdt@hse.ie**](mailto:referrals.dosmdt@hse.ie) **and cc** [**Audrey.collins@kare.ie**](mailto:Audrey.collins@kare.ie)  **If you would like to discuss this referral with a member of the team, you can contact.**  **Audrey Collins, Young Adults Disability Team Project Manager on 0874055997** | | | | | |

**Consent form for Adults**

The Young adults team are a clinical team who help young adults move from school to adult’s services/college .



You have sent a referral to the Young Adults team, asking us for help.

If you are not sure what the team will help you with, you can talk to us and we will explain what we do and how we can help you.



The Young adults team need your consent to help you. Consent is permission for the young adults team to help you. 

Easy read consent form for adults

Name: 



Date of Birth



Address:



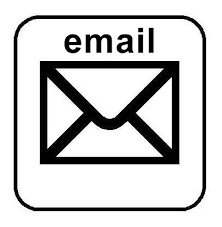
Phone number

Day sevice name

Young Adults consent form

I agree to the following (please tick below):

The Young adults team will receive information about me by email/post. This will let the team know that I would like their help



The young adults team may talk to me, my family, my doctor , my staff who help me to find out more information about me.



The Young Adults team will write notes in an electronic file. 

The Young adults team will keep information about me on file, such as name, date of birth, address, reports etc

I agree

I don’t agree

Consent to help from the young adults team

I want help from the Young Adults team. 

Name:

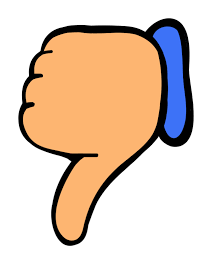
------------------------------------------------------------------

Signature:

---------------------------------------------------------------

Date:

---------------------------------------------------------------------

I don’t want help from the Young Adults team. 

Name:

------------------------------------------------------------------

Signature:

---------------------------------------------------------------

Date:

---------------------------------------------------------------------

Can you tell us why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Checklist 

Checklist for person making a referral on behalf of a young adult.

The following checklist can be used when making a referral to the Young Adults Team, on behalf a young adult. Completing the steps in this checklist will help you support the individual to decide about giving informed consent\* for a referral to be made to the Young Adults Disability Team and for their personal information to be shared with the team.

|  |  |  |  |
| --- | --- | --- | --- |
| **To Do** | | **Yes ** | **No**  **X** |
| Have you discussed the reason for referral with the individual? (Consider different aspects of life e.g., independence, social, education, and what goals the person wants to work on) | |  |  |
| Have you showed the individual the accessible information provided by the Young Adults Team?  (Information about the Young Adults Team, Sharing information and the Intake meeting) | |  |  |
| Have you used the individual’s preferred method of communication to discuss the referral?  (Video, pictures, Lámh signs, role play, etc.) | |  |  |
| Has the individual given consent for the referral?  (How has the person given their consent? E.g., video, Lámh signs, verbal, pictures)  Give details: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |  |  |
| **Checklist completed by:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name (in BLOCK CAPITALS)**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to person being referred**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date** | | |

Please submit the completed checklist with the referral form.

\*”for consent to be valid, the service user must have received sufficient information in a manner that is comprehensible to him or her about the nature, purpose, benefits and risks of an intervention…[ ]… Ensuring that information is provided in a manner that is comprehensible to the service user requires consideration of the quality of the communication between service provider and service user both in terms of the content of the information to be provided and of how that information should be provided” (The National Consent Policy, 2013)**