Young Adult Disability Team Referral Form

Criteria for Referral to the Young Adult Disability Team

- The Young Person attends or has accepted a place in a HSE-funded Adult Day Service in HSE Mid West Community Healthcare.
- The Young Person has or is due to leave school in 2022 or thereafter.
- The Young Person presents with complex needs that would not be more appropriately addressed within the uni-disciplinary or multidisciplinary framework of Primary Care Services.
- The Young Person left school within the last 3 years.
- The Day Service that the Young Person attends or is due to attend does not have provision for multidisciplinary team support as part of their Service Level Agreement.

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:**

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:**

School

Name of School:

Contact Details:

Year School Completed / Due to Complete:

School Principal:

Name of Year Head or school personnel with most knowledge / experience with the young

person:	
REASONS FOR REFERRAL	
What are the main concerns and priorities for the person and their family? **What would the person like support with?**	1. 2. 3.
Are there any supports/strategies already in place to support this identified need? **Please detail.**	
What outcomes does the person hope to get from this referral?	

OTHER COMMUNITY HEALTHCARE SERVICES
List all other services currently involved or waitlisted /previously involved with the young person.

Has the young person previously attended the Children's Network Disability team or other school age clinical teams? **Please provide details of team**	**Primary Care:** **Speech & Language Therapy** ☐ **Occupational Therapy** ☐ **Physiotherapy** ☐ **Psychology** ☐ **Other (please give details)** ☐
Mental Health Service ☐	**Tusla** ☐
Other (Please give details) ☐	

DAY SERVICE DETAILS

Day Service Name:	**Keyworker Contact Name:**
Specific Day service Location/Address:	**Key Worker phone number/email:**
Manager/Contact Person of Day Service:	**Manager phone number/email address:**

MEDICAL HISTORY (Attach any relevant Medical Reports)

General Practitioner (Name, address, contact number):

Relevant Medical History/Surgical Intervention:

NEURODIVERSITY / DIAGNOSES

Has the young person received any professional diagnoses indicating an Intellectual Disability, Autism, Sensory Impairment or others? Please Describe and attach relevant reports.

Current Medications:

Allergies/Adverse medication events:

Current investigations (Is the young person currently undergoing any health investigations or assessment?):

SOCIAL CIRCUMSTANCES

Relevant family and social history, for example; family health or housing difficulties, financial or employment problems, bereavement or other stressors.

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 provide any additional information here:

Please email your referral together with each of the documents listed below to: YADT@hse.ie

1. Completed YADT referral and appropriate consent form
2. Copy of the Occupational Guidance Profiling Tool
3. Copy of the Young Person's Person Centred Plan / Family Centred Plan / Individualised Plan
4. Copies of all relevant Professional Reports

Please password protect any documents which include identifying information before sending.
Please avoid using identifying client health information in the body of the email.

The Young Adult Disability Team (YAT)

Consent Form for Adults

The Young Adult Disability Team help young adults with their move from School to Adult Services.

The team is sometimes called the YADT.

You have asked for support from the Team.

If you are not sure what help the team will give you, you can talk to someone on the team.

The YAD team need your consent to help you. Consent is permission for the YAD team to help you.

About you

Full name (first name and surname):

Date of birth:

Gender (tick asappropriate):

☐ Male ☐ Female ☐ Prefer not to say

Home address:

Phone Number:

Day Service or Rehabilitative Training address:

I agree to: (please tick)

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

The YAD team will talk to me,
my family, my doctor, staff who help me.

The YAD team will write notes in my file.

My name, date of birth, address, and phone number
will be stored on a list by the YAD team.

I agree: ☐

I don't agree: ☐

Consent to help from the Young Adult team

I want help from the Young Adult Disability Team

Name:

Signature:

Date:

I don't want help from the Young Adult Disability Team

Name:

Signature:

Date:

If you don't want help from the YAT team can you tell us why?

Thank you for completing this form.

Referral to Young Adults Disability Team:

Checklist for person making a referral to the team, 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 Disability Team?		
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).