**Young Adults team Referral form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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. * 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: |  |   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. * Year young person finished school must be filled in. * 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 persons consent prior to sending the referral.  |  |  |  |  | | --- | --- | --- | --- | | **Date of Referral** |  | **Referrer name** |  | | **Referrer Occupation** |  | **Referrer email** |  | | | | | |
| **(A)YOUNG ADULT’S PERSONAL DETAILS** | | | | |
| **Surname** | | **First Name** | | |
| **Year young person left school** | | **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** |
| **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 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** | | |
| **Name of School Attended:**  **Contact details of school:**  **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 | | | | |
| 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 all the supporting documentation including**   * **Most up to date Psychological report** * **Discharge summary report if young person was linked with a CDNT** * **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:**  [**referrals.dosmdt@hse.ie**](mailto:referrals.dosmdt@hse.ie) **and cc** [**Audrey.collins@kare.ie**](mailto:Audrey.collins@kare.ie)**,**  **or post to: Young Adults team, HSE offices, Millenium Park, Naas Co, Kildare**  **If you would like to discuss this referral with a member of the team, you can contact**  [**yatadmin@kare.ie**](mailto:yatadmin@kare.ie) **or you can contact the Young Adults team on 0876824240** | | | | |

**Informed Consent**

In line with the Assisted Decision-Making (Capacity) Act 2015, capacity to consent should be assumed unless proven otherwise. The Individual Consent form is to be signed by the Person who is being referred.

The referral to Young Adults Team should be explained to the individual in a manner they understand by a trusted person who knows the Individual well, understands their communication needs, their will and preference, values and beliefs. Capacity to consent should be assumed unless proven otherwise.

Should you require additional support to explain Young Adults Team to the person, please contact us and we will be more than happy to provide support.

**Consent form for Referral to the Young Adults team** 

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



A referral has been sent to the Young Adults team, asking us for help.

The Young Adults team need your consent to gather this information and see if we are the best people to help you.



**How to fill out this form:**

If you are filling this form out for yourself, please fill out Section 1 and 2.

If you are filling this form out on behalf of an individual needing support fill out Section 1 and 3 only.

**Section 1: Young adult information**

Name   

Date of Birth

Address

Phone number

A group of people posing for a picture

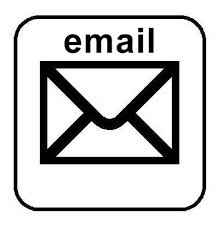
Description automatically generated 

Day service you attend if relevant.

**Section 2: Young adult consent form**

**I agree to the following (please tick at the end):**

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 team will need copies of reports, assessments, and other information about me.

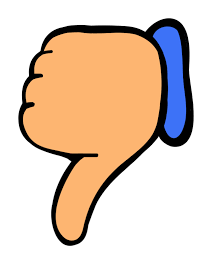


The team might need to talk to me, my family, doctor, staff or others who support you, to understand how we can help.



The Young adult’s team will keep information about me on file, such as name, date of birth, address, reports, notes etc.

I agree I don’t agree

Name: ---------------------------------------Date ---------------------------

Signature: ---------------------------------------------------------------------

**Section 3: Referral Checklist for person making referral on behalf of a young adult.**

The following checklist can be used when making a referral to the Young Adults team (YAT), on behalf of 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 team and for their personal information to be shared with the team.

|  |  |  |  |
| --- | --- | --- | --- |
| **To Do** | | **Yes** | **No** |
| 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? | |  |  |
| What communication methods were used to provide information about the referral e.g. Lámh, visuals, talking mats, videos (please specify)?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| How did the young person show their consent to the referral e.g. Lámh, visuals, gesture, verbal, talking mats (please specify)?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| If unsure if consent was obtained, what additional supports would help support the person to understand the referral to YAT? (consider the Individual’s communication needs, relevant previous referrals to support services, where the primary focus has been to support the person, the individual’s will and preference, values and beliefs).  Also, please specify if there is a decision-making agreement in place and the decision(s) listed within same?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Checklist completed by:** | | | |
| **Signature**    **Name (in BLOCK CAPITALS)**    **Relationship to person being referred**    **Date** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

*\*Informed consent: being given freely and not under threats or inducements, and where the patient has been given enough information in a way they can understand and can understand the nature, purpose and likely effect of the treatment. This means what exactly the treatment is, what the treatment is designed to do and what results it might have. The patients should also be able to understand the likely effects of refusing the treatment.*