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Young Adults Team,

Unit 3/4 St. John’s Court,

St. John’s Grove, Johnstown,

Co. Kildare W91 YO74.

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**Young Adults Team Referral form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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.  |  |  | | --- | --- | | 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.  |  |  |  |  | | --- | --- | --- | --- | | **Date of Referral** |  | **Referrer name** |  | | **Referrer Occupation** |  | **Referrer email and contact phone number** |  | | | | | |
| **(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**](mailto: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**](mailto:yatadmin@kare.ie) **or you can contact the Young Adults Team on 087-6824240** | | | | |