**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 Dublin, South Kildare and West Wicklow.
* Young adult presents with complex developmental disability related needs, which requires support from 2 or more disciplines on the Young Adults Team.
* Young adult’s 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. Failure to do so will cause delays processing referrals:**

* There is a clear reason for the referral, and you have specified what you hope the outcome of the referral will be.
* You have 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, and consent section at the end of the form is completed.

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| **Date of referral** |  | | |
| **Referrer name** |  | **Referrer occupation** |  |
| **Referrer email** |  | **Referrer phone number** |  |

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| **(A) YOUNG ADULT’S PERSONAL DETAILS** | | | |
| **Surname** | **First Name** | | |
| **Year young adult left school** | **Date of Birth** | | |
| **Gender** | | | |
| **Address**          **Eircode** | | | |
| **Family contact name** | | | |
| **Family contact phone number** | **Young Adult’s contact phone number** | | |
| **Family contact email address** | **Young Adult’s email address** | | |
| **Country of Birth** | **First Language**    **Other languages spoken at home** | | **Interpreter required (circle ‘yes’ or ‘no’)?**  **Yes               No** |
| **As 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 supporters?** |  | | |
| **Are there any supports/strategies already in place to support this identified need?**  **Please provide detail.**  (more space to write on next page) |  | | |
| **What outcomes do you hope to get from submitting this referral form?** |  | | |
| **Any 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.** **Incomplete referrals will cause delays as they will be returned to the referrer.** | | | |
| **(C) PREVIOUS CLINICAL SUPPORTS** | | | |
| **Has the young adult previously  attended the Children’s Network Disability Team or other school age clinical teams?**  **If so, please provide details of team.** | **Have they attended any of the following Primary Care teams?**   Shape**Speech & Language Therapy**  Shape**Occupational Therapy**  Shape**Physiotherapy**  Shape**Psychology**  Shape**Other (please give details)** | | |
| Shape**Mental Health Service** | Shape**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** **address** | | |
| **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 evnts** | | **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. | | | |

**Young Adults Team Consent form**

**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 young adult who is being referred.

The referral to Young Adults Team should be explained to the young adult in a manner they understand by someone who knows the person well, understands their communication needs, their will and preference, values and beliefs.

Information on the Young Adults Team in accessible format, including an introduction video for the team is available on the Young Adults Team website at https://[www.kare.ie/young-adults-team](http://www.kare.ie/young-adults-team)

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

If the young adult can consent to the referral being sent to the Young Adults Team, please complete the Young Adult’s consent form. If you feel the person’s capacity to consent is lacking, or is in question, the referrer must complete the checklist.

**Young Adult’s Consent Form**

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| **Name of Young Adult** | **Signature of Young Adult** |

**Yes, I agree:  or No, I do not agree  (please circle)**

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| I consent/do not consent to the following:  Email symbol clipart clipart kid 3 - ClipartixFor a referral to be sent by email/post to the Young Adults Team.  This referral will let the team know that I would like their help. It will include information about me such as my address, date of birth and any diagnosis I may have. | Thumbs up clipart 2 - Clipartix | manage your Google Workspace ... |
| SimplySfdc.com: Salesforce: Subscribe Reports in Classic and LightningFor the team to contact the HSE/other clinical teams who may have supported me in the past to get copies of reports, support plans, assessments, recommendations and other information about me. | Thumbs up clipart 2 - Clipartix | manage your Google Workspace ... |
| 21,900+ Adult Siblings Illustrations, Royalty-Free Vector Graphics & Clip  Art - iStock | Adult siblings talking, Adult siblings fighting, Adult  siblings arguingFor the team to talk to me, my family, doctor, staff or others who support me, to understand how they can help. | Thumbs up clipart 2 - Clipartix | manage your Google Workspace ... |
| Illustration vector graphic cartoon ...For The Young Adults Team to keep information about me on the team’s computer system. Information will include but not limited to name, date of birth, address, reports, notes etc. | Thumbs up clipart 2 - Clipartix | manage your Google Workspace ... |

**Where a person’s capacity to decide about an intervention is in question or lacking.**

When a person’s capacity to decide about an intervention is in question, may shortly be in question or is lacking this checklist may be useful to step through relevant considerations related to this referral.

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| **Checklist** | **Yes** | **No** |
| 1. Have you discussed the reason for referral with the individual? |  |  |
| 1. Have you shown the individual the accessible information provided on the Young Adults Team website? (https://[www.kare.ie/young-adults-team](http://www.kare.ie/young-adults-team)) |  |  |

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| 1. If the young adult was able to show their consent to the referral, how did they do this e.g. Lámh, visuals, gesture, verbal, talking mats (please specify)? |
| **The Decision support service promote the rights and interests of people who may need support with decision making. They register decision support arrangements and supervise decision supporters. More information on the decision support service and arrangements can be found on** [**www.decisionsupportservice.ie**](http://www.decisionsupportservice.ie)  **If there is a decision support arrangement in place that is registered by the Decision Support service, please answer Q4 and Q5**  **If there is no decision support arrangement in place, please go to Q6** |
| 1. Is there a legal decision support arrangement which is registered with the decision support service and if so, please specify what this arrangement is?   Decision making assistance agreement  Co-decision making agreement  Advanced Healthcare directive  Designated Healthcare representative  Decision Making Representative  Enduring power of attorney   * If there is a decision support arrangement in place, does this proposed request for intervention fall within the scope of this arrangement?   Yes  No |
| 1. Has valid consent been given via the relevant decision support arrangement under the ADM Capacity Act?   Yes  No   1. If there is no decision support arrangement in place, please answer the following questions:   Is the intervention for the benefit of the person and if so, please specify why?  It will optimise their health and well being  It is consistent with their will and preferences if ascertainable  It is consistent with their beliefs and values  It is consistent with the views of those consulted  Other   |  | | --- | |  |   Who was consulted and what were their views?   |  | | --- | |  | |
| **Checklist completed by** |
| **Signature** |
| **Name (in BLOCK CAPITALS)** |
| **Relationship to person being referred** |
| **Date** |

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| **Please email or post your referral with all supporting documentation including:**   * **Most recent 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  W91Y74    **If you would like to discuss this referral with a member of the team, you can contact the Young Adults Team at** [**yatadmin@kare.ie**](mailto:yatadmin@kare.ie) **or 087-6824240** |