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| **REFERRAL FOR YOUNG PERSON TRANSITIONING INTO ADULT SERVICES** |
| **Name**  | **Date of Birth:** |
| **NHS No:**  | **Gender:**  |
| **Contact Details:****Address:** **Telephone No:** **Key contact name & details:**  | **GP Name:** **GP Surgery Address:****Telephone No:**  |

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| **Referred By:** |  | **Date:** |  |
| **Profession/ Relationship:** |  | **Agency/ Team:** |  |
| **Address:** |  | **Telephone No:** |  |
| **Consent to share Information?** *If the young person does not have the capacity to consent please complete a mental capacity assessment and best interest decision* |  **Yes** | **No** |

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| **Other Professionals Involved:** |
| **Name** | **Profession** | **Name of Place of Work** | **Telephone No.** | **Overview Summary of their Involvement** |
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| I need you to know the following about my circumstances:Suggested prompts:Key needs: physical and mental health, wellbeingWhat does a good day look like for you?Future wishes/goals for education, employment, independent living, housing and health |

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| The people and places which matter in my life:Suggested prompts:Support networks friends/family/carers/meaningful contactsThings I like to do in the community Any support, paid or unpaid in place?Aids/adaptationsHealth inputAnyone you do not want in your life |

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| Any Risks? Is there anything in your conversation which you or anyone you know would worry about as being risky?How do you or others help to keep you safe?Are there any disagreements with regard to the identified risks?If “yes”, please explain:Are there any current risk assessments in place? Please provide a copy |

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| Key information:Do you have carer? Yes NoIf yes contact name and detailsAre you a young carer? Yes NoDo you have an advocate?If yes contact name and detailsWill you need an advocate? Yes No(for people who do not have anyone to support when having an assessment)Funding streamSocial care EducationContinuing heath care117 aftercare fundingWEEKLY COST- £ |

**Consideration of Care Act Eligibility**

**Things we need to consider under the Care Act eligibility conditions:**

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| Condition 1 |

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| I have needs related to a physical or mental impairment of illness  |

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| Condition 2 |

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| As a result of my needs I am unable to achieve two or more of the following outcomes:*(tick outcomes that you are not able to achieve)** Managing and Maintaining Nutrition
* Managing personal hygiene
* Managing Toilet needs
* Being appropriately clothed
* Being able to make use of my home safely
* Maintaining a habitable home environment

 * Developing and maintaining family/personal relationships
* Accessing and engaging in work, training education and volunteering
* Making use of necessary facilities in the local community including public

transport and recreational facilities and services* Carrying out any caring responsibilities for a child
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| Condition 3 |

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| As a consequence there is, or is likely to be, a significant impact on my well-being* Personal dignity including respect
* Physical and mental health and emotional wellbeing
* Protection from abuse and neglect
* Control over my day to day life
* Participation in work education, training and recreation
* Social and economic wellbeing
* Domestic, family and personal relationship
* Suitability of living accommodation
* My contribution to society
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Please attach any relevant documents such as latest EHCP, educational psychology reports and latest single assessment.

Once completed the form will need to be sent to (Tsdft.Transition@nhs.net)