**Autism Spectrum Condition (ASC) / Learning Disability (LD) Keyworker Referral Form**

**\*Mandatory**

|  |  |
| --- | --- |
| **\*Date of Referral:** | **\*Name of Referrer:** |
| **\*Email address of referrer:** | **\*Job title of referrer:** |
| **Young Person** | |
| **\*Forename:** | **\*Surname:** |
| **\*Date of Birth:** | **\*Gender:** |
| **\*Address:** | **\*Phone Number of parent/carer or YP if aged 16+:** |
| **\*Postcode:** | Email Address of Young Person if aged 16+ |
| **\*NHS Number:** | **\*GP Surgery:** |
| **\*Current Location of YP:**   * **Residential School** * **Inpatient – Ongoing** * **Inpatient – Awaiting Discharge** * **At Home – Independent or with Family** * **Placement – Registered** * **Placement –** **Non-registered** | **\*Using the attached referral criteria, where do you think the YP should be placed on the Dynamic Support Register (DSR)?**   * **Blue** * **Red** * **Amber** * **Green**   **Criteria included in Supporting Information.** |
| **\*Looked After Status:**   * **At home with parents** * **Child in Care** * **Child in Need** * **Looked After Child** | **\*Confirmed Diagnosis of:**   * **ASC** * **LD**   **Suspected Diagnosis of:**   * **ASC** * **LD** |
| **IT System:**   * **SystmOne/CarePlus/IAPTUS** |
| **Emergency Contact** | |
| **Contact Person 1** | **Contact Person 2** |
| **\*Full Name:** | **\*Full Name:** |
| **\*Relationship to YP:** | **\*Relationship to YP:** |
| **\*Phone Number of Emergency Contact:** | **\*Phone Number of Emergency Contact:** |
| **\*Email Address of Emergency Contact:** | **\*Email Address of Emergency Contact:** |
| **\*Additional Information:** | **\*Additional Information:** |
| **Lead Professional** | |
| **Name:** | |
| **Organisation or Team:** | |
| **Address:** | **Postcode:** |
| **Telephone Number:** | |
| **Email Address:** | |
| **Does this YP know about and consent to this referral?** | **Y/N** |
| **Does this YP consent to the Parent/Carer being contacted?** | **Y/N** |
| **\*Reason for Referral:** | |
| **\* Please confirm that verbal consent has been given by YP / Parent?** | **Yes /No** |
| **\*Keyworker Pilot Criteria Met and Why?** | |
| **\*Please confirm that this YP gives consent for their details to be held on the Dynamic Support Register. Please see supporting information for more details.** | **Yes/No** |
| **Please include all relevant information with the referral and list below:**  **(Social Care and Health Assessments / Minutes of Meetings / CETR Action Plans / EHCP)** | |
| **1.** | |
| **2.** | |
| **3.** | |
| **4.** | |
| **5.** | |
| **Keyworker Intervention discussed with Lead Professional?** | **Y/N** |
| **\*Contact Details of Professionals/Teams already involved in care of YP:** | |
| **1.** | |
| **2.** | |
| **3.** | |
| **4.** | |

|  |  |
| --- | --- |
| **\*Signed by:** | |
| **\*Print Name** | **Date:** |

**Please return referral form to: -** [cfhd.ldapkeyworkerteam@nhs.net](mailto:cfhd.ldapkeyworkerteam@nhs.net)