**North East London Learning Disabilities & Autism Keyworking Referral Form**

**Referral form to be completed by a professional not young person or parent/carer**

**Please complete all sections, any incomplete sections will lead to referral form not being accepted.**

**Send the completed form to** [**Keyworking@nelft.nhs.uk**](mailto:Keyworking@nelft.nhs.uk)

**Mandatory information**

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| **Date of Referral**: | |
| **SECTION 1: Eligibility for Keyworking** | |
| **Is this young person on a Dynamic Support Register (**[**DSR**](https://www.england.nhs.uk/wp-content/uploads/2023/01/Dynamic-support-register-and-Care-Education-and-Treatment-Review-policy-and-guide-infographic-scaled.jpg)**)?** | Yes  No    ***If no, please refer to DSR (as Keyworking service only works with CYP on DSR register)*** |
| **\*DSR Locality:**  City & Hackney Newham Tower Hamlets  Waltham Forest Barking & Dagenham  Havering Redbridge | **\*DSR RAG Rating on date of referral:**  Amber  Red  Blue |
| **Has consent been given for this referral?**  ***If you have selected ‘no' please provide further detail and/or refer to your*** [***DSR Lead***](https://www.nelft.nhs.uk/nel-keyworking-service-dynamic-support-register)***:*** | Yes  No |
| **Who gave consent?**  ***If you have selected other, please give details:*** | Parent  Young person  Best interest decision  Other |
| **Diagnosis (please tick as appropriate):**  Autism  Learning Disability  Other(s). Please Specify | **Age:**  Less than 18 years old  18 up to 25 years old |
| **Risk of Tier 4 Mental Health / Hospital Admission:**  Low  Moderate  High | **Risk description of low/moderate/high risk:** |
| **Any presenting risks or concerns that Keyworking should be aware of:**  Mental Health  Behaviour  Placement breakdown  Physical Health  Educational stability  Support gaps  Safeguarding  Other | **Description of risk or concerns Keyworking service should be aware of:** |
| **Referral Reason:**  Prevent Hospital Admission  Complex multiagency coordination  Advocacy  Delays/gaps in services  Transition support  Crisis stabilisation  Other | **Description of how Keyworking service can provide the necessary support:** |

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| **Section 2: Case information** |
| **Additional information:** *for example, relevant background, current events/situation, relevant clinic letters, DSR and or CTR referral form’* |

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| **SECTION 3: Young Person** | |
| **Forename:** | **Surname:** |
| **Date of birth:** | **Gender:** |
| **Address:** | **NHS number** (if known): |
| **Phone Number** (young person)**:** | **Email** (young person): |
| **GP name and address:** | **Social worker name and contact details if applicable:** |
| **Language spoken:** (Is an interpreter needed?) | **Communication needs:**(E.g. Non-verbal, visual aids, Makaton etc.) |
| **Nationality:** | **Ethnicity:** |

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| **SECTION 4: Parent or carer information** | |
| **Contact 1** | **Contact 2** |
| **Full name:** | **Full name:** |
| **Relationship to young person:** | **Relationship to young person:** |
| **Phone number:** | **Phone number:** |
| **Email address:** | **Email address:** |
| **Additional information:** | **Additional information:** |
| **Language spoken: (Is an interpreter needed?)** | **Language spoken: (Is an interpreter needed?)** |
| **Communication needs:** | **Communication needs:** |

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| **SECTION 5: Key Professionals** |
| **Please provide the contact details (name/email/telephone number) of professionals involved in CYP care:** |

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| **SECTION 6: Referrer** | |
| **Referral form completed by:** | **Relationship to young person:** |
| **Role:** | **Organisation & team:** |
| **Email:** | **Contact number:** |
| **Signature:** | |

Please submit the completed form to [Keyworking@nelft.nhs.uk](mailto:Keyworking@nelft.nhs.uk)