**Transitioning Young Adults Service Referral Form**

Please return this completed form to [thorpe.referrals@nhs.net](file:///%5C%5CARHCPRT01%5CProfiles%24%5Ckforeman%5CDesktop%5CTransition%20Documentation%5Cthorpe.referrals%40nhs.net%20)

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| **Consent** |
| Has the young person consented to this referral?   | YES / NO  |
| Is this a referral in the young person’s best interests due to lack of capacity? | YES / NO |
| If the young person is unable to consent, has the Next of Kin / Named Person / Local Authority agreed to referral? | YES / NO  |
| Family aware of and agree to referral? | YES / NO  |
| Has the young person/Next of Kin consented to sharing of information (EDSM)?  | YES / NO |
| Consent to contact young person by telephone or email? | YES / NO |
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| **Young Person’s Details** |
| Surname: |  | Forename(s): |  |
| Likes to be known as: |  |
| DOB: |  | NHS Number: |  |
| Address:Postcode: |  |
| Tel: |  | Mobile: |  |
| Email: |  |
| Gender: |  |
| Religion/ Beliefs: |  |
|  |
| Does the young person have additional needs related to:  | Vision | YES / NO |
| Hearing | YES / NO |
| Speech | YES / NO |
| First language or preferred method of communication: |  |
| Interpreter required: | YES / NO |
| Does Young Person have mobility issues? | YES / NO |
| If so, does young person require any mobilty aids? (Please list) |  |

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| **Next of Kin / Family details** |
| Next of Kin/ Main carer Name: |  |
| NOK/ Main carer Address:Postcode: |  |
| Relationship to Young Person: |  |
| NOK/ Main carer Tel: |  | NOK /Main carer Mobile: |  |
| NOK/ Main carer E-mail: |  |
| NOK/ Main carer first language or preferred method of communication: |  |
| Does NOK/ main carer require interpreter? | YES / NO |

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| Who lives at home with the Young Person?: |  |
| Current care provision:(Hospice/ Hospital/ residential school / Short Break provision): |  |
| Additional information such as any relevant current family circumstances |  |

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| **Diagnosis** |
| Diagnosis/Past Medical History: |  |
| Prognosis: |  |
| Is Young Person aware of prognosis? Further information: | Yes / No |
| Please include information that may be helpful with referral. (e.g., clinic letters, copy of Advance Care Plan etc) |  |

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| Current phase of illness: | Stable |  | ***If young person deteriorating or dying, please also refer to Specialist Palliative services.*** |
| Unstable |  |
| Deteriorating |  |
| Dying |  |
| Unknown |  |
| Has a Continuing Care/ Continuing Healthcare assessment been completed in the past year? | Yes / No |
| Has any Advanced Care Planning discussion taken place? If yes, please attach documentation. |  |
| Is there a resuscitation / ReSPECT plan in place? | Yes / No |

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| **Professionals involved with Young Person** |
| GP Name: |  | Tel: |  |
| GP Address:Postcode: |  |
| GP Email: |  |
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| Named Professionals*Please list all health or social care professionals known to Young Person’s current care* |
| Name | Hospital/ NHS Trust / Social Care provision | Speciality | Tel Number | Email |
|  |  |  |  |  |
| Please add any other information re: health or social care relevant to young person |
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| Reason(s) for referral?\*Transition Support/ Social eventsPain managementSymptom managementEmotional / psychological supportSocial / financialSpiritualCarer's needsPalliative rehabilitation needsOther |  |
| Is this referral for:(Tick one)   | Transition support / Social events |  |
| Community assessment and support |  |
| Day services |  |
| Inpatient Unit |  |
| What are you hoping we can help with? |  |
| Where would Young Person like assessment to be done? | Hospice | Yes / No |
| Virtual | Yes / No |
| At home | Yes / No |
| Other (please specify) |  |
|  |
| Referrer details |
| Name |  | Role: |  |
| Job Title |  | Organisation |  |
| Tel No |  | Email: |  |
| Signature |  | Date: |  |