**Transitioning Young Adults Service Referral Form**

Please return this completed form to [thorpe.referrals@nhs.net](file:///\\ARHCPRT01\Profiles$\kforeman\Desktop\Transition%20Documentation\thorpe.referrals@nhs.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 | |
|  | | | | | |
| **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: |  | | | | | | |
|  | | | | | | | |
| 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 events  Pain management  Symptom management  Emotional / psychological support  Social / financial  Spiritual  Carer's needs  Palliative rehabilitation needs  Other |  | | | | | |
| 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: |  | |