**REFERRAL FOR ADDITION TO THE DYNAMIC SUPPORT REGISTER (DSR)**

**NORTH EAST NORTH CUMBRIA ICB**

Please complete all sections of the referral form. Once completed please send to the email address at the end of the form. **Incomplete forms and those without information of consent will be returned.**

**PERSON REFERRED DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | DOB |  |
| Address |  | NHS No |  |
|  |  | Tel No |  |
|  |  | GP and Surgery |  |
| Current Accommodation Type |  |
| Advocacy Arrangements IMCA/IMHA/ OTHER |  |
|  |
| Diagnosis of Learning Disability | Primary?[ ]  | YES |[ ]  NO |[ ]
| Diagnosis of Autism Spectrum Disorder | Primary?[ ]  | YES |[ ]  NO |[ ]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Gender |  | Ethnicity |  | Religion |  |
| Language *(please include information about fist language and language used eg does the individual have communication needs or require information in a different format)* |  |

**REFERRER DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Referral |  | Referrer |  |
| Address |  | Position/Role |  |
| Email |  | Telephone |  |

**CONSENT**

|  |  |
| --- | --- |
| **Consent MUST be obtained, or a best interest process conducted. Evidence of this MUST be attached to this application. Without this the individual will not be discussed. Please see attached easy read document.** |  |

|  |  |  |
| --- | --- | --- |
| Does the person have capacity to consent?(has the young person been assessed as being Gillick competent)? | **YES** |[ ]  **NO** |[ ]
| Has the person consented to being added to DSR? | **YES** |[ ]  **NO** |[ ]
| If the person lacks capacity to consent has a best interest decision been completed? | **YES** |[ ]  **NO** |[ ]
| Has parental consent been obtained? | **YES** |[ ]  **NO** |[ ]
| **Please provide evidence of consent /capacity test and best interest decision (including date)** |

**PEN PICTURE**

|  |
| --- |
| Brief summary and background |
|  |

**RISK**

|  |
| --- |
| Please outline current risk (*what are the key reasons for escalation to DSR? What had been implemented so far?)* |
|  |
|  |
| Details of previous admissions (reason for current admission if inpatient)  |
|  |

|  |  |
| --- | --- |
| Care Coordinator |   |
| Social Worker |  |
| Is there a current care plan including risk assessment and treatment plan in place? Is there an up-to-date EHCP in place? |   |
| Date of last review of care plan/risk assessment |   |
| Are there any legal frameworks in place? |  |
| Is the person on S117 aftercare?Or Continuing Healthcare funded? |  |

**Previous C(E)TR information**

|  |  |  |  |
| --- | --- | --- | --- |
| Has there been a recent LAEP or C(E)TR | No [ ]  | LAEP [ ]  | C(E)TR [ ]  |
| If yes, please provide details (including date/s and outcomes) |   |
| Has there been an Enhanced MDT | Yes [ ]  |  No [ ]  |
| If yes, please provide details (including date/s and outcomes) |  |

**ADMISSION (please complete if person is an inpatient)**

|  |  |
| --- | --- |
| Initial date of continuous hospital admission |  |
| Date of transfer / step down to current hospital setting |  |
| Is patient ready for discharge in next 6 months? |  |
| Date of Planned Discharge |  |
| Confidence of Discharge Date being achieved |  |
| Section Status |  |

**FURTHER INFORMATION**

|  |  |
| --- | --- |
| Include information on what community support might be needed to prevent crisis, or at a time of increased need, including information on what the person may respond positively to and what support carers or family may need |  |

Please tick the correct area box below and email to nencicb.ctr.dsr.referrals@nhs.net

Please ensure your email is titled clearly in the subject line as follows: **DSR Referral – (add area)**

|  |  |
| --- | --- |
| **North Cumbria** |  |
| **Newcastle Gateshead** |  |
| **North Tyneside** |  |
| **Northumberland** |  |
| **South Tyneside** |  |
| **Sunderland** |  |
| **County Durham & Tees Valley** |  |