**JUCD Dynamic Support Pathway Referral Form**

**A DSP referral form will only be accepted where there is a confirmed diagnosis of learning disability and/or autism for people of all ages.**

**CONSENT**

**Consent is a mandatory requirement for addition to the DSP including any linked processes e.g. DSP meetings, C(E)TR and Keyworking Service.**

**Please note: If this referral form is received without consent/Best Interest Decision (BID) of the person, the form will not be actioned and returned to referrer.**

Consent/BID forms, including easy read versions, below for completion. use the most appropriate:

[DSP consent form .docx](https://nhs.sharepoint.com/%3Aw%3A/r/sites/msteams_e706b7/Shared%20Documents/Transforming%20Care%20Team%20September%202023%20Onwards/DSP/1.%20DSP%20Redesign%20January%202024/DSP%20documentation%20%28draft%29/FINAL%20Versions%2026.04.24/DSP%20consent%20form%20.docx?d=wc568405f16b74069b6a96dae7e079794&csf=1&web=1&e=pQTQzQ)

For further information please see all DSP guidance documentation (including easy read documents) available via this link[**https://joinedupcarederbyshire.co.uk/your-services/dynamic-support-pathway/**](https://joinedupcarederbyshire.co.uk/your-services/dynamic-support-pathway/)

**REFERRER DETAILS**

|  |  |
| --- | --- |
| **Name and Job Title:** | **Contact number and email address:** |
| **Team and Organisation:** |  |
| **Date referral completed:** |  |

**Once completed, this form including consent/BID is to be sent via password protected email (password to be sent in a separate email) to** **dhcft.ndpat@nhs.net**

Once the referral has been received, the ND Patient Assurance Team will contact the referrer to agree next steps, agree the urgency of the referral and outline linked processes required. During this discussion, the initial RAG rating will be reviewed and, if necessary, a joint decision will be made to change the rating (e.g., escalating or de-escalating risk as required).

**PERSON’S DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| **First name:** |  | **DOB:** |  |
| **Surname:** |  | **Gender / prefer not to say:** |  |
| **Other names known by:** |  |
| **NHS No** |  | **Local Authority Pin No:** |  |
| **Please indicate with a (X) MDT decision of current RAG rating based on clinical and professional judgement of current situation:****Date of MDT meeting where RAG agreed:** | **Red**Individual in a crisis situation and at risk of hospital admission |  |
| **Amber**Wellbeing is deteriorating - at risk of crisis if action not taken quickly potential hospital admission |  |
| **Green**Individuals whose wellbeing has settled and are no longer requiring DSP meetings |  |
| **Current registered GP Practice** **Named GP (if known):** |  | **Ethnicity / prefer not to say:** |  |
| **Address of usual residence:** |  |
| **Persons contact number and email address:** |  |
| **Parent/carers contact number and email address:** |  |
| **Type of accommodation (please indicate with (X) or add further information as appropriate):** | Independent Living |  | Residential placement |  |
| Family Home |  | Nursing/care home |  |
| Supported Living |  | Other (please specify) |  |
| **Confirmed Diagnosis (please indicate with (X) as appropriate) also indicate date of diagnosis and diagnostic tool used (if known):** | Learning disability |  | **Other relevant diagnosis/co-morbidities/physical health issues:** |
| Autism |  |
| Learning disability **and** Autism |  |
| **Any other relevant information** *e.g.**communication needs e.g.**Spoken language / interpreter needed / easy read documents / documents in another specified language etc* |  |

**CURRENT MDT / CARE TEAM**

|  |  |  |  |
| --- | --- | --- | --- |
| **Team** | **Name and contact number and email address** | **Team** | **Name and contact number and email address** |
| Social Care |  | Placement Manager / Team |  |
| Intensive Support Team (IST) |  | Forensic Team |  |
| Community Mental Health services / Crisis Team |  | Complex Behaviour Team |  |
| CAMHS |  | Advocate |  |
| Community LD Health Services / Nursing / OT / SALT |  | Education |  |
| Specialist Autism Team (SAT) |  | Police / Probation  |  |
| Case Manager/Care Co-ordinator |  | Keyworker |  |
| Psychiatry |  | Psychology |  |
| Other (please add any relevant information): |  |
| **Please state reason for DSP referral** *(as much information as possible and what has led to current situation, including any medication or physical health issues):* |
| **Is an adult or Tier 4 hospital admission being considered and why?** *(please provide relevant details):* |

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| **ND PAT OFFICE USE ONLY** |
| **Date referral form received:** |  |
| **Date of initial review by NDPAT Team (names) and action plan:**  |  |
| **Date of referral/notification review with referrer (names) and agreed plan:** |  |
| **Date confirmation email sent to referrer:** |  |
| **Date added to BT and number:** |  |
| **Date added to Register:** |  |
| **Date of first DSP Meeting:** |  |