Referral Form for Children and Young People (CYP) with Possible or Diagnosed NDD (Autism/ADHD) and/or Behaviours that Challenge

This referral form is for the12 week Neurodiverse Provision being delivered by The Green Light Trust at:

Lawshall, near Bury St Edmunds: **Primary age** – Wednesdays 22nd Sept to 15th Dec (excluding half term week)

**Secondary age** – Mondays 13th Sept to 6th December (excluding half term week)

Martlesham Heath, near Ipswich: **Primary age** – Fridays 24th Sept to 17th Dec (excluding half term week)

**Secondary age** – Wednesdays 22nd Sept to 15th Dec (excluding half term week)

Referrals for all conditions will be made using this one referral form (not condition specific).

This form is in 3 parts:

* Part 1 - Information
* Part 2 – to be completed in full
  + CYP
  + and their family
* Part 3 –one person from below to complete
  + GP or another clinician
  + School/Preschool/College
  + Other professionals involved in the CYP’s care e.g. voluntary sector organisation

Please **complete all sections of the form**, to enable us to assess the needs of the child or young person. Please note that this form may be copied to Home Start Suffolk <https://www.homestartinsuffolk.org/> who are acting as a triage to assess referrals onto our service, on behalf of Suffolk CCGs (Clinical Commissioning Groups).

Both parts then need to be sent via a single point of contact:

Part 1 – Information Please complete in full

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| --- | --- |
| Name of Young Person |  |
| Birth Gender |  |
| Gender Identified as |  |
| Date of Birth |  |
| Home Address (inc postcode) |  |
| School/Pre School/Post School  Name and Address |  |

Ethnicity - please tick

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| White | British |  | Asian or Asian British | Indian |  |
|  | Irish |  |  | Pakistani |  |
|  | Gypsy/Roma |  |  | Bangladeshi |  |
|  | Any Other background |  |  | Any Other Asian background |  |
| Mixed | White & Black Caribbean |  |  | Chinese |  |
|  | White & Black African |  |  | Any Other Ethnic Group |  |
|  | White & Black Asian |  | Black or Black British | Caribbean |  |
|  | Any Other |  |  | African |  |
| Prefer not to say | |  |  | Any Other Black |  |

Additional Information – please tick

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Adopted | Looked after Child | EHCP | | Child Protection Plan | | Child In need | Interpreter Required |
|  |  |  | |  | |  |  |
| Name of Primary Carer | | |  | | | | |
| Relationship to Young Person | | |  | | | | |
| Legal Parental Responsibility? | | | Yes/No | | | | |
| Lives in Family Home | | | Yes/No | | | | |
| Contact Numbers, and best time to contact | | | Mobile | |  | | |
| Home | |  | | |
| Work | |  | | |
| E Mail Address | | |  | | | | |

|  |  |  |
| --- | --- | --- |
| Name of Other Carer/Significant Adult: |  | |
| Relationship to Young Person |  | |
| Legal Parental Responsibility? | Yes/No | |
| Lives in Family Home | Yes/No | |
| Contact Numbers, and best time to contact | Mobile |  |
| Home |  |
| Work |  |
| E Mail Address |  | |

**Please indicate which services the child/young person has accessed/ is accessing**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Service | Named Professional | Contact Number | Date of contact | Advice Given |
| Hospital Consultant |  |  |  |  |
| Community Paediatrician |  |  |  |  |
| Child and Adolescent Mental Health |  |  |  |  |
| Speech and Language Therapy |  |  |  |  |
| Occupational Therapy |  |  |  |  |
| Additional Needs Team |  |  |  |  |
| Children’s Disability service |  |  |  |  |
| School or College |  |  |  |  |
| School Nurse |  |  |  |  |
| Educational Psychology |  |  |  |  |
| Social Care |  |  |  |  |
| Specialist Education Services |  |  |  |  |
| Health Visitor |  |  |  |  |
| Early Help |  |  |  |  |
| HomeStart |  |  |  |  |
| SEND Support |  |  |  |  |
| Other: Please list |  |  |  |  |
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Part 2a – Parent/Carer

*We need to get a sense of the issues that you and your young person are facing. Please provide key information………*

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| Please describe your current concerns about your young person. This might be at home, at school or somewhere else. You may attach an additional sheet if necessary. |
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| Looking back please describe concerns about your young person when he/she was younger, and as they have been growing up. You may attach an additional sheet if necessary. |
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| Please describe your young person’s current living circumstances and any difficulties they or you may have encountered, (e.g. bereavement, marital breakdown, parental mental health issues etc.) |
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| Please describe any medical issues that your young person has had. This might include illnesses or accidents. |
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| Please describe any issues that your young person has with school/college. This might include impact on the young person’s learning. |
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| How worried are you about your young person?  You might want to talk about the impact that their behaviour has on you, your family and your life |
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| What help/advice has already been accessed and when, and what was the outcome? |
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| Please provide any additional information that you think might help us get a complete picture of your young person.  For example, you might want to talk about likes/dislikes, their social skills, routines, friends/attachments, sleep or eating patterns, what makes them happy/anxious/sad  We would like to make sure that we have a balanced view so it would be good to also understand the strengths and aspirations of your young person. |
|  |

Part 2b – Young person

*This section is optional, but your young person may want to explain how they feel as well. They can draw or write and can share as little or as much as they would like.*

*Below are some suggestions about things they might like to share*

* *My likes/dislikes (for example music, being outside….)*
* *What I am good at.*
* *My favourite things*
* *Who I feel close to…?*
* *I worry about….*
* *I am scared of….*
* *I get upset when…*
* *What I would like to happen next*
* *What I would like to be different….*

What I would like you to know about me:

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| --- |
|  |

Part 3

|  |  |
| --- | --- |
| Name of person making the referral |  |
| Organisation |  |
| Organisation Address |  |
| Role |  |
| Contact telephone number |  |
| E mail address |  |
| Referral Date |  |

Please describe your concerns regarding this child:

Attach additional sheets if required – for a school this may be an AANT assessment

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| --- |
| Summary of reasons for referral  To include why you are concerned about this young person, with your own observations |
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| What is your involvement with the young person and/or family? |
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| Do you have any safeguarding concerns? |
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| Is there anything you would like to add (advice, help, suggestions…) to help us understand the difficulties that have resulted in this referral. |
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| Please outline support that has already been provided.  For example Graduated Response, AANT |
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| Is there anymore that you can add to provide a picture of this young person?  For example, communication or language issues, awkward and/or troublesome behaviour issues |
|  |

Please provide name and contact details of the person who is taking the lead on this referral:

|  |  |
| --- | --- |
| Name |  |
| Telephone |  |
| E mail |  |
|  |  |

The lead person will need to ensure that the form is fully completed and will be the point of contact for all queries relating to completion