RISE NAVIGATION HUB - REFERRAL FORM

Please return all forms to:
RISE - Navigation Hub, Paybody Building, Stoney Stanton Road, Coventry CV1 4FS
Tel: 0300 200 2021 / Fax: 024 7696 1579

Please note this referral will be triaged by a clinician to decide the most appropriate commissioned service the CYP should be seen by, from the following services:

- CWPT Specialist Services (including Neurodevelopment & Learning Disabilities - *see Appendix 1 for referral guidance for LD)*
- Coventry and Warwickshire Mind
- Primary Care Mental Health
- Other CWPT services if deemed appropriate (e.g. Adult Mental Health if CYP is aged 17 or above or Community Paediatrics)

If the referral does not meet the criteria for any of the above commissioned services, we will reply to you with recommendations of other agencies you could refer to.

Please provide as much detail as possible in this form, to enable the referral to be comprehensively triaged and without delay.

SECTION ONE: (All of this section **must be completed by the referrer** to avoid any delay)

Please complete in black ink only

Date of Referral:

1. What type of referral is this?

Urgent i.e. CYP at risk of harm to self or others (delete as appropriate) Yes/No
Routine (delete as appropriate) Yes/No

2. What service is this referral is for:

Rise/CWPT Specialist Services (delete as appropriate) Yes/No
Coventry and Warwickshire Mind (delete as appropriate) Yes/No

CHILD/YOUNG PERSON'S DETAILS	
Title:	Date of Birth:
Forename:	Surname:
Also Known As:	Gender:
Marital status:	Sexuality:
Religion:	
Address at which CYP is currently living:	Post Code:
NHS No:	CYP Email Address:
CYP Phone/Mobile:	Home Phone/Landline:
Ethnic Origin:	1st Language (if not English):

Is an interpreter required? Yes/No	School/College:
REFERRER'S DETAILS	
Name:	Job Title/Profession:
GP Practice or Organisation:	Email Address:
Address: Post Code:	
Phone No:	Date of Request:

Complete if referrer detailed above is not CYP's GP **GP DETAILS**		
Name:	GP Practice:	
GP Practice Address: Post Code:		
Phone No:	Email Address:	
REFERRAL CONSENT		
Delete as appropriate		*If answered no, please give reason*
Does the parent/carer know about the referral?	Yes / No	
Does the parent/carer know about the referral?	Yes / No	
Does the parent/carer consent to a social communication/ASD assessment if the CYP is presenting with symptoms suggestive of ASD?	Yes / No	
Does the CYP know about the referral?	Yes / No	
Does the CYP consent to the referral?	Yes / No	
Does the CYP consent to the parent/carer being contacted?	Yes / No	
FORWARDING CONSENT		
Delete as appropriate		*If answered no, please give reason*
Does the parent/carer given consent for the referral to be forwarded to the Paediatrics or Adult Mental Health Teams if appropriate?	Yes / No	
Does the CYP give consent for the referral to be forwarded to the Paediatrics or Adult Mental Health Teams if appropriate?	Yes / No	

PARENT/CARER DETAILS (INCL PARENTAL RESPONSIBILITY)	
Parent/Carer (1)	Parent/Carer (2)
Full Name:	Full Name:
Address: Post Code:	Address: Post Code:
Relationship to CYP:	Relationship to CYP:
Holds parental responsibility? Yes / No	Holds parental responsibility? Yes / No
Phone (Home/Landline):	Phone (Home/Landline):
Phone (Mobile):	Phone (Mobile):
Email Address:	Email Address:
1st Language (if not English):	1st Language (if not English):
Has/does access mental health services? Yes / No	Has/does access mental health services? Yes / No
Support needs (e.g. access, interpreter, filling in forms):	Support needs (e.g. access, interpreter, filling in forms):

<u>If parent/carer(s) listed above do not hold parental responsibility, provide details of person who does:</u>	
Full Name:	Relationship to CYP:
Address: Post Code:	
Phone (Home/Landline):	Phone (Mobile):

OTHER PERSON(S) WITHIN FAMILY / HOUSEHOLD					
First Name	**Family Name**	**DOB**	**Relationship to CYP**	**Known to RISE? Y/N**	**Same Address? Y/N**

DETAILS OF CYP'S SPECIALIST NEED *Delete as appropriate*		
Does the CYP have a formal diagnosis of ASD?	Yes / No	If yes: mild / moderate / severe
Does the CYP have a diagnosed learning disability?	Yes / No	If yes: mild / moderate / severe
Does the CYP have any other disabilities?	Yes / No	If yes, please provide details:
Does the CYP have a substance misuse problem?	Yes / No	If yes: alcohol / drugs / other
Any other known diagnosis (mental or physical)?	Yes / No	If yes, please provide details:

CHILD/YOUNG PERSON'S STATUS	
Delete as appropriate	
Living with parents	Yes / No
Living with relatives	Yes / No
CAF	Yes / No
Looked After Child	Yes / No
Subject to Child Protection Plan	Yes / No
Adopted	Yes / No
Constant supervision required	Yes / No
Young carer	Yes / No
Other (please provide details):	
If LAC or CPP were ticked, the CYP's allocated Social Worker's details must be completed before the referral is processed	

SOCIAL WORKER DETAILS	
Name of Allocated Social Worker:	
Social Workers Team:	
Address:	Post Code:
Telephone Number:	
Email Address:	

CYP's LEGAL STATUS	
Delete as appropriate	
Interim Care Order	Yes / No
Full Care Order	Yes / No
Section 20 Voluntary accommodated	Yes / No
Freed for Adoption / Placement Order	Yes / No
Special Guardianship	Yes / No
Residence Order	Yes / No
Other (please provide details):	
Is the CYP part of legal proceedings	Yes / No
If yes, please give details of the Guardian and date of hearing:	

REASON FOR REFERRAL

Please detail mental health and behavioural concerns for the CYP, including severity/frequency/length of time over which they have been presenting/impact on the CYP's daily life:

Please detail any previous interventions/services accessed (LABS or LAWS, CAF, Education Psychology, NSPCC, SIBS, Counselling, Triple P, Stepping Stones, Autism Parent Training Course, Early Bird etc.) and outcome:

Please provide relevant information around functioning – any cognitive deficits / learning difficulties / communication issues:

What outcome(s) are you expecting for the CYP?
Delete as appropriate

Improved general physical health	Yes / No
Improved physical development	Yes / No
Improved communication	Yes / No
Improved emotional/social development	Yes / No
Improved behaviour	Yes / No
Improved self esteem	Yes / No
Improved family and social relationships	Yes / No
Improved self-care skills	Yes / No
Aspirations Achievement in learning	Yes / No

Please provide further details below:

APPENDIX 1 - LD REFERRAL GUIDELINES

Level of Learning Disability

Overall, children and young people matching the descriptions in the two right-hand columns will meet the criterion for the Children's Learning Disability team in terms of having a moderate to severe learning disability.

Typical abilities and needs		**Level of Learning Disability**		
		Mild learning disabilities	**Moderate learning disabilities**	**Severe/profound learning disabilities**
Communication	**Expressive language**	Often delayed – but usually able to use everyday speech and hold conversations	Delayed and limited – typically acquire the use of only simple phrases/manual signs	Few words only or speech absent
	Comprehension	Often delayed – explanations may need to be simplified to aid understanding	Delayed and limited – typically to understanding simple phrases or requests	Very limited understanding if any
	Non-verbal communication	Good	Limited	Very limited – only family carers would be able to interpret
Adaptive Functioning	**Self-care**	Fully independent in majority of areas (eating, washing, dressing, continence etc.)	Some supervision required in majority of areas. Mainly continent.	Constant supervision/ support always required in all areas. Mainly incontinent.
	Academic	Difficulties with reading, writing and arithmetic common	Limited – may develop basic literacy and numeracy skills	Severely limited – focus is often on acquiring other skills
	Mobility	No delay in development	Delayed but usually full mobility is achieved	Often severely limited with frequent musculoskeletal abnormalities (and sensory impairments common)
	Social	Social immaturity common (more impaired if comorbid ASD)	Limited – but often acquire the basic social skills necessary for interaction	Restricted (and ASD common)
Education		Usually in mainstream school	Usually in a special school	Always in special school
Overall support needs		Limited – intermittent and focused support usually needed (e.g. at times of transition)	Extensive – regular, long term support needed in at least some environments	Pervasive – contact, high intensity support needed across all environments
Mental health needs		Needs and presentation similar to children without learning disabilities	Diagnosis often dependent on third-party reports or observing changes in behaviour	Difficulty diagnosing – severe and chronic behavioural difficulties common

Associated Deficits	No associated deficits	Some increase in Central Nervous System disorders, like epilepsy	Significantly increased health needs, higher rates of epilepsy, sensory impairments and physical disabilities
A comparison of terminology			
CAMHS/Health	**Mild learning <u>disabilities</u>**	**Moderate learning disabilities**	**Severe/profound learning disabilities**
Pre-school	*Mild developmental delay*	*Moderate developmental delay*	*Severe/profound developmental delay*
Education	*Moderate learning <u>difficulties</u>*	*Severe learning <u>difficulties</u>*	
This guidance is based on the ICD-10 diagnostic criteria and the DSM-V. Categorising a diverse group of people in this way risks overgeneralisation and the overshadowing of individual needs. No firm conclusions should ever be drawn from a young person's IQ score on its own, and nor whether they access mainstream or special education.			