***Who should be referred?***

*The Dynamic Support Register (DSR) is for people who have been diagnosed with a learning disability, or Autism, or both.*

*If the individual is added to the DSR their care will be routinely reviewed in combination with their support network to make sure that all the best practice for young people with a Learning Disability and/or Autism is in place.*

*The DSR is intended to aid early identification of individuals who may be at increased risk and help services to proactively support them in the community to avoid unnecessary admissions.*

***Who the service is not for:***

* *A suspected diagnosis of a mild Learning Disability;*
* *A diagnosis of a specific learning difficulty only, such as dyslexia, dyspraxia etc as this is not the same as a Learning Disability;*
* *A suspected diagnosis of Autism.*

|  |  |  |
| --- | --- | --- |
| **QUESTION** | **YES** | **NO** |
| Is the individual or parent/carer aware of this referral? If no, please use the box below to explain e.g. if the individual the referral is for lacks capacity, who will provide best interests decision. |  |  |
|  | | |

**TO BE COMPLETED BY REFERRER**

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial** | **NHS Number** | **Date of Birth** | **Permanent Address** |
|  |  |  |  |
| **Completed by:** |  | **Date:** |  |
| **Diagnosis** | **Autism** | **Learning Disability** | **Date of Diagnosis** |
|  |  |  |

*This is a quick and simple YES or NO section – please tick relevant box*

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| **QUESTION** | **YES** | **NO** |
| Is the individual at risk of admission to a psychiatric hospital? |  |  |
| Has the individual had or been considered for a C(E)TR? |  |  |
| Has there ever been a previous admission?  If so; please elaborate in summary box below |  |  |

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| **BRIEF SUMMARY OF HISTORY AND CURRENT RISK:** |
|  |

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| --- | --- | --- |
| **PRIMARY REASON FOR REFERRAL** |  | |
| *(Please select most appropriate)* | **YES** | **NO** |
| Family Breakdown |  |  |
| Education Placement Breakdown |  |  |
| Challenging Behaviour |  |  |
| Support required for Parent/Carer |  |  |
| Harm to Self |  |  |
| Harm to Others |  |  |
| Other |  |  |
|  |  |  |

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| --- | --- | --- | --- |
| **CARE STATUS:** | **Child in Care Y/N**  **Adopted Child Y/N**  **Child Protection Y/N**  **Child In Need Y/N**  **Early Help Y/N**  **Family Support Service Y/N**  **Care Leaver Y/N**  **Shared Lives Y/N**  **Residential Care Y/N**  **Supported Accommodation Y/N** | | |
| **(please delete as necessary)** |
| **EHCP:** | **Applied for?** | **Granted:** | **Refused:** |

|  |  |  |
| --- | --- | --- |
|  | **NAME** | **CONTACT DETAILS/BASE** |
| **MAIN CARER(S)** |  |  |
| **CONSULTANT PSYCHIATRIST** |  |  |
| **CARE COORDINATOR** |  |  |
| **COMMUNITY CONSULTANT** |  |  |
| **GP** |  |  |
| **SOCIAL WORKER** |  |  |
| **SCHOOL CONTACT** |  |  |
| **OTHER PROFESSIONALS**  **INVOLVED** |  |  |

**Please email this form to KeyworkingDSR@berkshire.nhs.uk**

**All referrals will be screened weekly by the team. The remainder of this form will be completed between you and a Dynamic Support Navigator (DSN), at your consultation slot.**

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**TO BE COMPLETED AT CONSULTATION BY DYNAMIC SUPPORT NAVIGATOR**

|  |  |  |
| --- | --- | --- |
| **DOCUMENTATION** | **YES/NO** | **DATE** |
| RISK ASSESSMENT |  |  |
| CARE PLAN |  |  |
| GP LETTER/MEDICATION |  |  |
| MOST RECENT SOCIAL CARE PLAN |  |  |
| SEND WELCOME PACK |  |  |

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| --- | --- | --- | --- |
| **Last seen:** |  | **By whom:** |  |

|  |  |  |
| --- | --- | --- |
| **Consent to participate with, and receive support from the Keyworking Team Berkshire West:** | The individual and Parent/Carer(s) have had a copy of the DSR & Keyworking Team Berkshire West Leaflet: | **Y / N** |
| The individual has consented to participate with, and receive support from the Keyworking Team Berkshire West: | **Y / N** |
| *If the individual DOES NOT have capacity to make this decision to participate with, and receive support from the Keyworking Team Berkshire West, a best interests decision will need to be undertaken.* | |

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| --- | --- | --- | --- | --- | --- |
| **Move to consultation:** | **Yes** | **No** | **If No, Signposting provided:** | **Yes** | **No** |
|  |  |  |  |

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| --- |
| **Signposted to:** |
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| --- | --- | --- |
| **Chronology/Deep Dive**  *(Timeline of individuals journey using RiO notes, Document View and Connected Care from birth to present. Include diagnosis dates and any admission to a mental health unit dates)* | | |
| **Date** | **Age** | **Information** |
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| **INDIVIDUAL’S VIEW** |
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| **FAMILY’S VIEW** |
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| **OTHER PROFESSIONALS’ VIEWS** |
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| **OUTCOME AND PLAN** *(to be completed by the DSN once consultation is completed and the check list above actioned), including clinical judgment and Clinical Support Tool scoring for RAG rating:* |
|  |
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| --- | --- | --- | --- |
| **Initial Triage**  Date: | RED |  | Who consulted on RAG rating and rationale? |
| AMBER |  |
| GREEN |  |