***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.*

-------------------------------------------------------------------------------------------------------------------------------------

**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*

|  |  |  |
| --- | --- | --- |
| **QUESTION** | **YES** | **NO** |
| Is the individual at risk of admission to 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* |  |  |

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

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

**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.**

--------------------------------------------------------------------------------------------------------------------------------------

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **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**  **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** |  |  |

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

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

|  |
| --- |
| **INDIVIDUAL’S VIEW** |
|  |

|  |
| --- |
| **FAMILY VIEW** |
|  |

|  |
| --- |
| **OTHER PROFESSIONALS’ VIEWS** |
|  |

|  |
| --- |
| **OUTCOME AND PLAN** *(to be completed by the DSN once a review of care notes is completed and the check list above actioned), including clinical judgment and Clinical Support Tool scoring for RAG rating:* |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial Triage**  Date: | RED |  | Who consulted on RAG rating and rationale? |
| AMBER |  |
| GREEN |  |