**Guidance for completion: *To avoid delay and/or referrals being rejected please complete all sections of the referral form – if all sections are not completed, we reserve the right to reject the referral.***

**A referral for a medication/annual review cannot be considered without a diagnostic report and most up to date medication information including date of and the attached clinic letter of last review, or if assessment was done historically clear evidence of ADHD diagnosis**

**We accept individuals under the below criteria:**

* **The person is 18 years old or above** at the time of the referral.
* **The person is not at risk to oneself** being sufficiently stable to keep himself/herself safe throughout assessment, i.e., is not engaging in significant self-harm or attempts on own life.
* **The person is not at risk of harming others** such that the assessor or other people accessing the service will be safe from physical attack.
* **The person’s substances and/or alcohol** use is not at a level that may interfere with observational assessments/ability to engage in assessment process.
* **The person’s BMI** is above15.
* **The person does not have dementia** and is not going through the diagnostic process for dementia.
* **The person has given explicit consent** as indicated below.

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| **Please confirm that the person you are referring into the service meets the criteria listed**  |   **Yes** [ ]  **No** [ ]  |

**We accept** referrals for clients with a Learning Disability however these are only accepted if the following has been confirmed- we will reject the referral without inclusion of the following information:

* Consent has been confirmed or Mental Capacity assessment completed to prove inability to consent and then consent from Guardian
* Information is provided on the person’s level of cognitive functioning, by providing cognitive/functional assessment reports.
* Information is provided on reasonable adjustments needed to complete assessment including access, communication needs
* Risk information is provided based on triggers likely to increase likelihood of behaviours that challenge (a functional analysis if possible)

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| **Date of Referral:** **Referral Needed:** *(Please put x in box)* | [ ]  **ADHD Medication Review:** Person has a diagnosis of ADHD (at any age) and is currently on medication or is looking to trial medication for suitability – *referral cannot be considered without a diagnostic report and most up to date medication information including date of and the attached clinic letter of last review - or if assessment was done historically clear evidence of ADHD diagnosis*[ ]  **ADHD Annual Medication Review:** Person who requires annual medication reviews, person has a diagnosis of ADHD (at any age) and is currently stabilised on medication for ADHD and is under shared care with their GP - *referral cannot be considered without a diagnostic report and most up to date medication information including date of and the attached clinic letter of last review, or if assessment was done historically clear evidence of ADHD diagnosis*[ ]  **ADHD Annual Medication Review, Transition to Adult Services:** A transition case for a young person diagnosed with ADHD who is turning 18 who requires annual medication reviews now under Adult services - Person has a diagnosis of ADHD (at any age) and is currently stabilised on medication for ADHD - *referral cannot be considered without a diagnostic report and most up to date medication information including date of and the attached clinic letter of last review, or if assessment was done historically clear evidence of ADHD diagnosis* |
| **Persons full name:**  |  |
| **NHS Number:**  |  | **Patient’s CCG** |  |
| **Date of Birth:**  |  |
| **Gender:** |  |
| **Ethnicity:** |  |
| **Contact Details:**  | Address: |
| Telephone: | Mobile: |
| Email: |
| **Person’s preferred contact method:***(Please**indicate*) | Telephone [ ]  Text [ ]  |
| Mobile [ ]  Email [ ]  |
| Post [ ]  After 3 attempts at contacting the client, if there is no engagement the client will be discharged from our service – please update us with any change in contact details |
| **Does the person consent to this referral?**  | Yes [ ]  No [ ]  |
| **Date consent was agreed:** |  |
| **Please specify name and contact details of other people the individual consents to being contacted (e.g., parents)** | Name:Phone number:Email: |

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| **Person completing referral and contact details if not GP** **Referrer Name & Contact Details:** **Profession:**  |  |
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|  |
| **Registered GP contact details:**  |  |
| **Other agencies involved in persons’ care:** *(Please specify contact details)***Please include here any Mental Health support input.**  |  |
| **Current/co-existing mental health or history of mental health issues**  | *Any Mental Health diagnosis known**Any relevant mental health reports are required – please attach with referral* |
| **Current or historic risks to self or others, including any suicide attempts or self-harm** | *Please include any details* |

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| **Current Medication:** *(Please attach a copy of the health record)* |  |
| **Date of last medication review:** | *Please include the clinic letter from this appointment – this is required.* |
| **Any physical health problems:** *(Please attach any relevant reports- required)* | **Yes / No****Please provide details:** |
| **Does the person or immediate family members have any cardiovascular issues?** | **Yes/No****Please provide details:** |
| **Has the person been diagnosed with a learning Disability (IQ below 70 and with functional difficulties)?**  | **Yes/No/Suspected but not confirmed***If yes or suspected please ensure we receive all relevant reports and provide all known information.* |
| **Any reasonable adjustments needed?**  | ***Yes / No*** *E.g., accessible entrance, communication needs.*  |
| **What other services is the person receiving support from?** | *E.g., Learning Disability Team, Social Care**If the client has a named Support Worker or named Care Coordinator, please provide full details including Name, Profession, Service and all contact details.* |
| **Is an interpreter required for the person?**  | *Please provide full details* |
| **Name and contact no. of next of kin or person to contact in an emergency:** | *Name:* | *Contact No.**Relationship to person:* |

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| **Data Protection:**  |
| By submitting this form, you agree that you have obtained the consent of the person who the information is about. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For the purposes of this form The Retreat York is the data controller for the collection, processing, sharing and storage of this data. All information collected in this form will be treated confidentially and will be used for the sole purpose of providing a clinical service to the person above. Their information may be passed onto third parties who help support us in the provision and administration of our services or where we have their consent to do this. Please note, this confidentiality is not absolute and may be broken where we have a legal obligation to comply with the law for e.g., the information is required to identify potential fraud or to detect a crime or to apprehend an offender or where there is a rising safety or safeguarding issue. Further information about this can be found in our Privacy Notice on our website at: <https://www.theretreatclinics.org.uk/>**.** Alternatively, you can contact our Data Protection Officer for further information at: The Retreat York, 107 Heslington Road, York, Y010 5BN or email us at: DPO@TheRetreatYork.org.uk. |

***Autism and ADHD Service use only:***

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| *Date referral received:*  |
| *Date discussed in referral meeting:*  |
| *Any further information needed:*  |
| ***Acceptance of referral:*** Yes [ ]  No [ ]  |
| *Next Steps:*  |