

**Children & Young People’s (CYP) Dynamic Support Register Referral Form**

The CYP Dynamic Support Register (DSR) is for children and young people up to the age of 18, with a diagnosed Learning Disability and/or Autism and who are at high risk of being admitted to a mental health hospital or placement breakdown. Its purpose is to help get the right care and treatment in the community, by working with the person, their family and their support network and by promoting better joint working across services.

Completed referral forms should be sent to [Bromley.DSR@selondonics.nhs.uk](mailto:Bromley.DSR@selondonics.nhs.uk)

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| **Consent:**  (Consent must be obtained to add a person to the DSR. Where a child or young person is under the age of 16 or over 16 and unable to give informed consent as defined by the Mental Capacity Act, this must be given by the parent or those with parental responsibility. Where consent is not given, but there remains significant concerns then a Best Interest (BI) decision can be made). |
| **DSR consent/BI obtained? Y/N** (if yes, please submit with referral) |

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| **Referrer Details:** | | |
| **Name:** | **Role:** | **Contact Details:** (email/phone/organisation) |
| **Relationship to young person:** (e.g. designated social worker/care co-ordinator, self-referral or parent/carer) | | **Date of referral:** |
| **Lead Professional Details:** (if different to referrer, provide the primary point of contact for information about the child or young person – e.g. Social Worker or Care Co-ordinator) | | |

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| **Child/Young Person’s Details:** | | |
| **Name:** | **D.O.B:** | **NHS Number:** |
| **Gender:** | **Ethnicity:** | |
| **Where is the child/young person currently living?** (e.g. at home, residential or semi-independent placement, educational setting, etc.) | | |

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| **Reason for Referral:** | | |
| **Details of Learning Disability/Autism diagnosis:** | | |
| **Details of Mental Health diagnosis:** | | |
| **Details of Physical Health diagnosis:** | | |
| **Summary of Current Risks/Concerns** (incl. reasons for possible hospital admission/placement breakdown) | | |
| **Risk of Inpatient Admission:** (please tick – see risk matrix tool for guidance) | | |
| **Red** (High) | **Amber** (Medium) | **Green** (Low) |
| **Has a Care Education Treatment Review (CETR) Taken Place? Y/N** (if yes, please provide details, incl. dates) | | |
| **Is there a Deprivation of Liberty Safeguards (DoLS) in place?** (if yes, please provide details) | | |

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| **Social Care Plans:** | |
| **Is there a designated Social Worker? Y/N**  (if yes, please provide details) | **Are they a Child Looked After (CLA) or Care Leaver?** **Y/N** (if yes, please provide contact details) |
| **Does the child/young person have a Child in Need Plan (CiN Plan)?** **Y/N**  (if yes, please provide details): | |
| **Does the child/young person have a Child Protection Plan (CPP)?** **Y/N**  (if yes, please provide details): | |
| **Does the child/young person have any other statutory plans or assessments? Y/N**  (if yes, please provide details): | |
| **Are there any open safeguarding concerns? Y/N** (if yes, please provide details): | |



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| **Education Plans:** | |
| **Does the child/young person have an Education Health and Care Plan EHCP) or a Funded Inclusion Plan (FIP)? Y/N**  (if yes, please provide details) | **Is there a designated Educational Health Care Plan Coordinator? Y/N**  (if yes, please provide contact details) |
| **Details of Education Setting (incl. SENCO or school contact details where applicable) :** | |

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| **Mental Health Treatment Plans:** | |
| **Is the child/young person currently or previously open to CAMHS? Y/N**  (if yes, please provide details) | **Is there a designated CAMHS Care Co-ordinator? Y/N**  (if yes please provide contact details) |
| **Is the child/ young person eligible for S117 aftercare? Y/N**  (If yes, please provide details of Section history - including dates and types) | |

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| **Care Packages:** |
| If the child/young person has a package of care or placement, please provide details of:  **The Funder**: (ICB/Local Authority)  **The Provider**: (Organisation Name and address, key contact details)  **Details of the support package/placement**: |



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| **Additional Information:** |
| If there is any additional information that will support the referral that has not been covered, please provide here. |