**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.***

**Due to the high demand for the service, and due to commissioner changes, we are only able to receive new direct/urgent referrals that meet the below criteria – all other ‘routine’ referrals should be directed to the Online platform provided through the ICB.**

**For URGENT REFERRALS Please note we will not accept where a date or proof or urgency is not provided.**

It is essential that you provide further information/evidence & attachments where applicable regarding criteria met, including up to date risks assessment completed and most recent mental health reports. If you are unsure what information to provide with the referral, please contact The Retreat for guidance.

We can only complete assessments if clients are sufficiently stable and risks are suitably managed; we only complete assessments where there is need to confirm a diagnosis **(not to rule it out as a diagnosis);** there needs to be clear evidence provided on this form of difficulties being present since childhood; for complex cases we would encourage arranging clinical discussions with the clinical team at The Retreat during the referral process.

**Please note we are unable to guarantee that the person referred will be seen for their assessment prior to their specific date when requesting an URGENT referral.**

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| **Referral Type**  |  **Urgent** [ ]  **Direct** [ ] **(Urgent due to time limitations)****(Direct due to non-use of online platform)***If this referral is urgent, we aim to accommodate an assessment within the constraint of time associated with the referral however we cannot always guarantee this.* |
| **If ‘Urgent’, please give details of urgency and dates associated that are reflected within the listed criteria.**  |  |

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| Direct referral via primary care where a lack of diagnosis and patient's need for reasonable adjustments to access major healthcare treatments e.g., hospital treatment, operations, care homes etc.**Evidence must be provided.** | Further evidence/information  | Date of planned treatment/access to care If urgent referral:  |
| Direct referral via primary care where a lack of diagnosis affects, employment/court decisions e.g., family breakdown, custody hearing, armed forces etc. **Evidence must be provided.** | Further evidence/information  | Date of planned court/custody hearing if urgent referral:  |
| (Other) Direct referral via healthcare professional for people under their care where it is identified that a diagnostic decision due to urgency (please provide date that provides urgency rationale)**e.g. employment tribunal, loss of housing, financial loss etc.** **Evidence must be provided.**  | Further evidence/information  | Date associated with urgent request:  |
| Direct referral via TEWV/CMHT for people under their care where it is identified that a diagnostic decision and in depth understanding of a person's presentation is required in order to: * Identify the appropriate support provision/network beyond TEWV mental health support (ie to support discharge planning)
* To prevent further mental health crisis.

Where possible these cases will be reviewed by the clinical teams at planned MDT discussions prior to offering any assessment. | Further evidence/information |  |

**In addition to the above criteria please confirm:**

* **The person is 18 years old or above** at the time of the referral.
* **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 is deemed stable enough to undergo the assessment process (e.g. not in crisis, has recovered from recent acute episode of mental illness)**
* **The person’s BMI** is above15.
* **The person does not have Dementia or a significant Brain injury** and is not going through the diagnostic process for Dementia or needing specialist support for their Brain Injury
* **The person has given explicit consent** as indicated below.

**We accept** referrals for clients with a Learning Disability however these are only accepted if the following has been confirmed- Please note 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)**

***PLEASE NOTE – TO AVOID delay and referrals being rejected please complete*** *all* ***sections of the referral form. This includes Part B of the Autism section where the person can give as much information as possible to be returned with the form.***

***If you are at all unsure about whether the individual would qualify, please contact us, using the contact details at the bottom of this page.***

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| **Date of Referral:** **Referral Needed:** *(Please put x in box)* | Autism Diagnostic Assessment [ ]  ADHD Diagnostic Assessment [ ]  |
| ***We require all referrals for ADHD to include an initial screening tool and score (Wender-Utah). Please attach the completed form.***

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| ***Wender Utah ADHD scale***  | ***Score:***  |

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| **Persons full name:**  |  |
| **NHS Number:**  |  | **Patient’s CCG** |  |
| **Date of Birth:**  |  |
| **Gender:** |  |
| **Ethnicity:** |  |
| **Contact Details:**  | Address: |
| Telephone: | Mobile: |
| Email: |
| **Best way to contact individual:***(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:** |   |
| **Does this person have an Intellectual / Learning Disability?**  | Yes/No (if yes please provide details) |
| **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 give details of any other agencies involved in client’s care in the last 3 months)***Please include here any Mental Health support input.**  |  |
| Have you had any other assessments that maybe relevant to the diagnostic assessment process? **Please add details here and attach as separate documents.** |  |
| **Summary of** **Challenges (Autism):**(The characteristics of autism are divided into three main groups (examples given). **Please give examples** for **all three areas**. Please use the tick boxes and add additional information where necessary.   | **Please only fill in this section in if you are referring for Autism assessment****Part A (To be completed by referrer)** **1) Social Communication** [ ] with verbal and non-verbal communication (e.g., eye contact modulation /difficulty. understanding facial expressions)[ ] starting/maintaining/give-and-take of conversation, small talk, literal understanding of language, difficulty. understanding sarcasm**Examples** (must be completed) **2) Social interaction** [ ] understanding other’s emotions/point of view[ ] fitting in socially[ ] initiating and maintaining relationships[ ] preferring to spend time alone, finding people confusing/unpredictable**Examples** (must be completed)**3) a) Routines/Rituals; b) Highly focussed and intense interests; c) sensory sensitivities** [ ] fixed daily routines[ ] uncomfortable with change, cope better with preparation [ ] intense interest in specific, highly focussed areas of interest[ ] hyper-/hyposensitive to one or more senses**Examples** (must be completed)**4) Have the above difficulties been present in childhood?**(Note as autism is developmental it is important that challenges are longstanding) **Part B (To be completed by person being referred)** **Please could you provide examples of why you believe you may be autistic?**(If you struggle to answer please ask people who know you well to support you to fill in the form)**Examples may include the reasons why you feel different to others. This maybe in the areas of social communication and interaction, difficulty with coping with changes and how you experience the world.** (must be completed) |
| **Summary of** **Challenges (ADHD):** Please give examples for **all areas**. | **Please only fill in section in if you are referring for ADHD assessment.**If you are referring for an ADHD Medication Review or Annual Medication Review, you will need to complete a different referral form.1. **Poor Attention and concentration (Occasional hyperfocus is common)** (must be completed)
2. **Impulsive behaviours** (must be completed)
3. **Poor Organisation skills** (must be completed)
4. **Restlessness, difficulty. keeping quiet and interrupting others, irritability/quick temper** (must be completed)
5. **Have the above difficulties been present in childhood?**

**(Note as ADHD is a developmental condition it is important that challenges are longstanding)** (must be completed) |
| **Current/co-existing mental health or history of mental health issues**  | *Please state here any Mental Health diagnosis known**Any relevant mental health reports are required – please attach with referral.* |
| **Current or historic risks to self or others** | *Please include any details* |
| If the person has had a recent episode of mental illness, please can you confirm they have fully recovered and are stable enough to complete a diagnostic assessment. If you are unsure, please contact the clinical team at The Retreat to discuss with them.**Yes** [ ]  **No** [ ]  |

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| **Current Medication:** *(Please attach a copy of the health record)* |  |
| **Any physical health problems:** *(Please attach any relevant reports)* | **Yes / No** |
| **Any reasonable adjustments needed?**  | ***Yes / No*** *E.g., accessible entrance, communication needs.*  |
| **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. |