# Progression to Adulthood Referral Form

## Adult Social Care

**To prevent delay and enable a detailed triage to be undertaken please ensure you have completed this referral form fully.**

| **CONSENT TO THE REFERRAL**<br>Is the young person being referred aware of the referral and have you sought consent? | | | | | |
|---|---|---|---|---|---|
| YES | | NO | | Unable to consent (due to MH needs/LD in line with Mental Capacity Act) | |
| **PLEASE NOTE THAT WE ARE NOT ABLE TO PROGRESS WITH THE REFERRAL UNLESS CONSENT HAS BEEN SOUGHT AND THIS SECTION HAS BEEN COMPLETED.** | | | | | |
| Signature of young person being referred: (or note of verbal consent given)<br><br>Date: | | | | | |

| **DETAILS OF THE PERSON BEING REFERRED** | |
|---|---|
| Date of Referral: | Title: |
| First Name: | Family Name: |
| Preferred Name: | Date of Birth: |
| Ethnicity: | Gender: |
| Address: | Telephone Number:<br><br>Email Address: |
| Current Accommodation (please tick):<br><br>Living with family ☐<br>Living alone ☐<br>Supported living ☐<br>Residential/Nursing home ☐<br>Living with adult carer ☐<br>Other ☐ | Best Contact Method (please tick):<br><br>Telephone the person directly ☐<br>Telephone a carer ☐<br>Text ☐<br>Email ☐<br>Contact referrer ☐<br>Other ☐ |
| Is the person a British National or UK Citizen? | NHS Number (if known): |

| **FURTHER INFORMATION** | |
|---|---|
| Is the young person known to Children's Social Care? * Please provide relevant information/plans (including ICS #). If Looked After please specify. | Yes/No |
| Does the young person have an EHCP or SEND Support? *If yes, please attached EHCP/Support Plan and name of school | Yes/No |
| Is the young person known to CAMHS? *Please provide relevant information/plans | Yes/No |
| Does the young person received support from Continuing Care? | Yes/No |
| What is the young person primary need/diagnosis? (Please add as much detail as possible) | |
| Cognition and learning (do they have Global Learning | |

| | |
|---|---|
| Disabilities IQ 70 or below – if so, please refer directly to ILDP Transition Team) | |
| Physical and/or Sensory | |
| Communication & Interaction (ASC) | |
| Social and Emotional Mental Health | |
| Long-term medical conditions | |

| **To help us determine the appropriate next step please indicate which Care Act outcomes you think are strengths and areas of support for the young person – (strengths – what can the young person do for themselves)** | | |
|---|---|---|
| | Strengths | Areas for support |
| managing and maintaining nutrition | | |
| maintaining personal hygiene | | |
| managing toilet needs | | |
| being appropriately clothed | | |
| being able to make use of the adult's home safely | | |
| maintaining a habitable home environment | | |
| developing and maintaining family or other personal relationships | | |
| accessing and engaging in work, training, education or volunteering | | |
| making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services | | |
| carrying out any caring responsibilities the young person has for a child. | | |

| | | |
|---|---|---|
| | | |

## WHAT IS THE PRESENTING NEED/REASON FOR REFERRAL?

## RISK ISSUES

Please provide details of any risk issues that we need to be aware of (i.e. risks towards the person; risks towards others; risks of a professional visiting them alone etc)

## DETAILS OF REFERRER

| | |
|---|---|
| Name: | Address: |
| Role/Title: | |
| Tel no: | Email: |
| How long have you known the young person? | |
| What is your relationship to the young person? | |

## GP DETAILS

| | |
|---|---|
| Name: | Practice Address: |
| Tel no: | |
| Email: | |

Once you have completed the form please send this to the Access and Advice Service using one of the following methods:


**Phone** 020 7527 2299
**Fax** 020 7527 5114
**Email** access.service@islington.gov.uk
**Secure Email** accessservicesecure@islington.gcsx.gov.uk
**Address:** **7 Newington Barrow Way London N7 7EP**


*Access please pass to Progression to Adulthood Team via the LAS referral tray.