CHILD AND YOUNG PERSON - DSR REFERRAL PROFORMA

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| **Name and role of person completing** |  |
| **Date of completion** |  |
| **Name of CCG and or LA** |  |
| **Name of service user** |  |
| **Any ID numbers (e.g AT, Paris etc)** |  |
| **Address (including any provider name)**  |  |
| **Date of birth** |  |
| **Details of any previous admissions (if known)** |  |
| **Diagnosis (primary needs)**  |  |
| **Does the person have capacity?** |  |
| **Has consent been obtained (if not why not)** |  |
| **Is there a requirement for Best Interests under Mental Capacity Act?** |  |
| **Has there been a recent C(E)TR and or LAEP? (provide details)** |  |
| **Who is the current social worker?** |  |
| **Are any other professionals involved?** |  |
| **Are there any legal frameworks currently in place?** |  |
| **Is the person on S117 aftercare?** |  |
| **What are the key reasons for escalation to the CYP DSR? (please provide details of the presenting problem and what has been implemented)** |  |
| **For completion by the CYP DSR co-ordinator** |
| **Has the person been recorded on the CYP DSR?** |  |
| **Is a LAEP and or C(E)TR required?** |  |
| **What actions have been agreed/taken and by whom?** |  |
| **Please advise the RAG rating status for the CYP DSR** |  |
| **Will this be discussed at the next CYP DSR network meeting?** |  |
| **Name and date of DSR co-ordinator** |  |