Transition Panel

Initial Referral Document

(Please ensure this document is approved by your Team Manager before submitting)

**Details of young person:**

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| --- | --- | --- | --- | --- |
| **Surname** | **Forename(s)** | **DOB** | **Age** | **Address** |
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| **status: LAC, Foster Placement, Living at home , semi independence (16+); in a \*hospital setting (detained or as a voluntary patient)** |  | **Locality / team / school etc** |  |
| **Referred by? And on what date?** |  |  |  |

\* Referral route - Transitions panel / contact centre/ Mental health Gateway

**Family Composition:**

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| **Name** | **Relationship** | **DOB** | **Address** |
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Any young carers in the house hold? If so please indicate who.

Please indicate who is the main carer for the young person – are they a natural or paid carer?

**Details of referral:**

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| **Brief History of Case** | |
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| **Any Current provision and cost** | |
| Include costs weekly / annual – who agreed, when, until when, has it been reviewed? | |
| **Schools attended** |  |
| **Educational level of functioning? (Formerly this may have been an IQ score)**  **When was this assessed?**  **Who assessed it?** |  |
| **Primary area of need (Complex needs, Learning disability, sensory impairment, Mental health etc)** | Please note Mental health referrals will likely be signposted. |
| **Which areas from the ‘assessing eligibility for Adult services’ document do you believe apply? Why?** |  |
| **Educational statement / EHCP (yes / no and date)** |  |
| **Capacity Assessments – Has capacity building work taken place? – to consent to the referral?** |  |
| **Best Interests Meetings- any taken place and if so what for?** |  |
| **Has the young person consented to this referral being made?**  **(Yes or No)** | Please note – unless detail of the consent are available the referral will be unable to be progressed |
| **When did you discuss this with them?** |  |
| **If not has whoever holds parental responsibility consented to this referral being made?** |  |
| **Are there any other professionals involved?** |  |

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| **Carers – Natural support** |
| If they are a young carer or a natural support (not paid) carer – have they been offered a carers assessment? Tell us about their decision… |

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| **Interventions already explored** |
| Include what worked, what didn’t, and why? |
| Does this include any restrictions (deprivation of liberty)?  If so, can you give us some examples of the restrictive care? |
| **Are health interventions in place? If so who? And what is their role?** |
| School nurse, CAMHS, specialist consultants etc |
| **Request being made to panel** |
| What are your expectations from Transition Team? |
| **Resource currently in place** |
| Tell us about – is this in place, likely to be needed post 18, is an increase needed etc Is this monthly, weekly, how much and who currently funds? |
| **Has a preparation for adulthood review taken place?** |
| **When? Who was there? What is the plan for post 18? For the young person and the carer(s) (as Applicable)…..** |
| **Plan / Timescale** |
| Include age of person in years and months – what are their hopes and aspirations for adulthood? |

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| **Is this referral late? What are the circumstances around this?** |
| Please note anything from 17.3 years will be classed as late. |

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| **FOR PANEL USE** | | | |
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| **Request Agreed** | | **YES** | **NO** |
|  | | | |
| **Resource Allocated** | | | |
|  | | | |
| **Review Date** |  | | |

\*\*Please email completed forms to: [transitionpanel@manchester.gov.uk](mailto:transitionpanel@manchester.gov.uk) \*\*