Referral for Residential Services and High Needs Placements:-

The purpose of this referral information is to:

* Assess the fit between the needs of the young person and access to high needs placement
* Provide information needed by the specialist care provider to allow them to consider the match between the young person’s needs and the care they offer AND
* To start to understand the needs of the young person so they can match them to a caregiver and start to organise the support needed

All young people referred to the High Needs National HUB MUST have a Gateway Assessment referral underway or completed.

**Referrals for young people where no Gateway referral has been sent to the Gateway Co-ordinator will be declined until the referral is made.**

Referrals for residence with no Gateway referral will be assessed on a case by case basis.

Please complete all fields in the referral form. This form is designed so that you can use the same information from the Gateway referral and add to it as needed. You do not need to re-write sections – if information is up to date for Gateway; use it for this referral.

All fields in the Referral Form must be completed-or Referral Form will be returned.

Birth Certificate and IRD (if appropriate) must be attached.

For IDEA services placement - a cover letter is required explaining what services you are looking for.

For TPAR or Group Homes with Barnardos and Richmond a CBT referral must be attached.

For Residential Requests – you must complete the Residential Referral Section – setting out level of urgency and why secure care is required.

Hard copies of all assessments must be provided. **We will not accept a note of “refer to CYRAS”**. Provide as much information as possible in the referral hub form as this will assist the provider to understand the young person’s personal behaviour. List all whanau placements, approved and unapproved (under Placement History).

|  |  |  |
| --- | --- | --- |
| DD | MM | YYYY |

**1 Date Sent to Regional Hub:**

**2 Recommendation for Referral:**

|  |
| --- |
| Programme Type Requested (i.e.: Residential, Behavioural 1:1, Group Living HSB, IDEA services):  |
| Why do you need a specialist care placement? |

**3 Gateway Assessments**

Status (Please select one from the following)

|  |  |
| --- | --- |
| Referred to Gateway Coordinator has been made | **Y/N** |
| Date: | Gateway Co-ordinator name: |
| Contact Details:  |

**Or**

|  |  |
| --- | --- |
| Gateway Assessment completed and attached with referral | **Y/N** |

**Or**

|  |  |
| --- | --- |
| Youth Justice Health and Education Assessment attached | **Y/N** |

**4 Child or young person’s details**

|  |  |
| --- | --- |
| First name(s): | Family name: |
| Preferred name/also known as: |
| CYRAS ID |
| Date of birth: | Age | Gender |
| Ethnicity: Iwi/Tribal affiliation |
| Individual Needs (identity and cultural requirements): |
| Care and protection Legal status and date of next review of court plan: |
| Youth Justice Legal Status and date granted: |

**5 Social worker**

|  |  |
| --- | --- |
| Site | Date of Referral |
| Social workers Name |
| Address |
| Phone number: (Please include DDI and External Number) | Cell Phone: |
| Email |
| Supervisor |
| Phone number: (Please include DDI and External Number) |
| Email |

**6 Significant people to the child**

(Include: parents, grandparent’s guardians, caregivers, siblings and others,)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Role | Name(s) | Relationship to the child | Available for respite care/contact only/post placement/not available | Contact details(address, phone number and best time to contact) |
| Parent 1 |  |  |  |  |
| Parent 2 |  |  |  |  |
| Caregiver |  |  |  |  |
| Grandparents |  |  |  |  |

**7 Parent:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DOB: | Age | yrs.’ | Deceased  | **Y/N** |
| Major medical/health conditions:(Include any drug and alcohol, mental health, chronic diseases or impairments the parent may have) |

**8 Parent:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DOB: | Age | yrs.’ | Deceased  | **Y/N** |
| Major medical/health conditions:(Include any drug and alcohol, mental health, chronic diseases or impairments the parent may have) |

**9 Is the Child/Young Person adopted? Y/N**

(This means either legally adopted or whangai)

**10 Agencies/Professionals involved:**

(include paediatrician, GP, Education provider, TWB clinical advisor ACC, other health services, lawyer for child, school health nurse, RTLB, NASC/Disability services Special Ed, etc., and state whether the young person is on TWB Preventing Suicide Programme where applicable)

|  |  |  |  |
| --- | --- | --- | --- |
| Role | Name and contact details | Nature of involvement | Specify current services provided |
|  |  |  |  |
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**10 Relevant information about the child or young person:**

(This section should copied from Gateway Referral if completed and added to if necessary)

|  |
| --- |
| Provide information below that will help the provider understand the child or young person’s life experiences, background and needs AND their care needs. Include comments and analysis of: |
| Adverse life events – family violence, parental separation, loss of caregiver, abuse, neglect, injuries |  |
| Care attributes including strengths and resiliencies of the child or young person |  |
| Health concerns or issues including hospital admissions |  |
| Emotional and behavioural issues or concerns- should be supported by assessments attached |  |
| Mental health diagnoses  |  |
| Education achievements and difficulties  |  |
| Siblings in care or previously in care (name) |  |
| Self-harming or suicidal behaviours |  |

**11 Care and Protection Plan:**

|  |  |  |
| --- | --- | --- |
| DD | MM | YYYY |

**Next Plan Review Date:**

|  |
| --- |
| What is the permanency care goal for the child or young person? |
| Timeframe to achieve this goal?  |
| What is the concurrent care goal of the child or young person? |
| Actions in the plan? (add more rows as required) |
| **1** |  |
| **2** |  |
| **3** |  |
| **4** |  |

**12 Education Profile**

*(Attach to this referral if completed)*

Please provide the status of the Gateway Assessment education profile and date the education profile was requested from the school /RTLB provider

|  |  |
| --- | --- |
| Gateway Assessment/Education Profile Status *(Select Applicable Option)* |  **Completed/ Referred/ Not Yet Referred** |
| Date Referred/Completed |  |
| Name of School/RTLB Provider |  |

**13 Placement History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Placement type(most recent first) | Start date  | Length (months) | What worked well in this placement for the young person AND what didn’t work well in this placement for the young person | Why did this placement end |
|  |  |  |  |  |
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**14 Identify any alerts**

*(e.g. gang affiliations, threats and harassment from whanau, violence, sexualised behaviours etc )*

Add rows as required

|  |  |
| --- | --- |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |

**15 Request for Care and Protection Residential Placement**:

**this section is compulsory if you are recommending Residential Placement**

Please advise key points which evidence the level of urgency and need for a residential placement (add rows as required)

|  |  |
| --- | --- |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |
| 6 |  |

**16 Specific Behaviours or Risks you wish to be addressed or managed in care**

(Please provide any assessment relevant to these behaviours as an attachment to this referral)

|  |  |  |
| --- | --- | --- |
| Behaviour/Need(short description e.g. fire lighting, suicide risk) | Assessed by (if applicable e.g. Psych report) | Plan to Manage (e.g. CAMHS)  |
|  |  |  |
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**17 Medication: If the young person is currently prescribed medication you MUST complete the following:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Medication | Duration of Course | Prescribed by | Reason/s of Prescribed Medication | Known Allergies |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**18 Any People that the Child/Young Person must not have contact with?**

|  |  |  |  |
| --- | --- | --- | --- |
| Role | Name | Relationship to Child/Young Person | Reasons for Non-contact |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

**19 Documents attached to support the referral**

You must attach any of the following that are available:

|  |  |  |
| --- | --- | --- |
| Assessment Type  | Name of Provider/Contact Details | Attached |
| Gateway report  |  | **Y/N** |
| Education Profile |  | **Y/N** |
| Report from psychologist in last 5 years |  | **Y/N** |
| Previous school report |  | **Y/N** |
| Education Assessment (from GSE or private psychologist) |  | **Y/N** |
| All specialist medical reports from last 5 years  |  | **Y/N** |
| Genogram |  | **Y/N** |
| Assessment tool (new)  |  | **Y/N** |
| Three Houses  |  | **Y/N** |
| Current Wellstop/SAFE Assessment(must be provided for HSB request0 |  | **Y/N** |
| Alcohol and Drug Assessment  |  | **Y/N** |
| Copy of Custody Order  |  | **Y/N** |
| Copy of current NASC Assessment if referral is made to IDEA services  |  | **Y/N** |
| Copy of Birth Certificate and IRD (If applicable)  |  | **Y/N** |

**20 Day Activities**

|  |  |
| --- | --- |
| Is the young person attending a school or education facility | **Y/N** |
| If NO please outline, what are they currently doing during the day? |

**21 Youth Justice Component (if applicable)**

|  |  |
| --- | --- |
| Current charges: |  |
| Date Youth Justice FGC held |  |
| Next Youth Court date (if applicable) |  |
| Offending history (including if the young person is/was a child offender and if an application for declaration was made by Police). |
| Attach a copy of any YJ bail conditions, plan or (restraining or protection) orders currently in place. |

**22 Young Persons Views**

|  |
| --- |
| What is the young person’s view about the proposed placement/programme option? |

|  |  |
| --- | --- |
| Have you attached a 3 Houses or narrative of child/young person’s views about their plan (provided by the young person) | **Y/N** |

**23 HCN Plan**

|  |  |
| --- | --- |
| Do they have a current HCN application or plan?  | **Y/N** |
| Have they ever had an HCN Plan? | **Y/N** |
| Name of the IMG for current HCN application or plan? |
| Does the current plan or application include a care component? | **Y/N** |
| If YES, please outline |

**24 Sign Off**

|  |
| --- |
| Prior to sending to the Regional Hub, please ensure that the Site Manager/Budget Holder completes a CYRAS case note endorsing this referral.  |