# **Dynamic Support Register (DSR)**

# **Self-Referral Form**

#  The Dynamic Support Register (DSR) is a list of people with a diagnosed Learning Disability (LD) and/or Autism who have very complex needs and who may be at risk of being admitted to a mental health inpatient hospital. For further information please see appendix 1.

# Please be aware of who you are sending personal information to. If you do not have access to a secure email account and are not comfortable sending the information requested below by email, then please contact the team – nwicb.cypm@nhs.net.

|  |  |  |
| --- | --- | --- |
|  | **Date of referral** |  |
|  | **Full Name** |  |
|  | **Date of Birth** |  |
|  | **NHS Number** |  |
|  | **Gender** |  |
|  | **Address** (Please indicate if this is home address, placement, or residential setting) |  |
|  | **Telephone** |  |
|  | **Email address** |  |
|  | **Ethnic origin** |  |
|  | **Next of kin** | Name: Relationship: Address: Telephone: Email:  |
|  | **Registered GP Practice** | Named GP: Surgery: Address: Telephone:  |
|  | **Professionals involved**(Please include the details of all health, social care and education professionals involved with your/your child’s care) | Name: Job Title: Address: Telephone: Email: Name: Job Title: Address: Telephone: Email: Name: Job Title: Address: Telephone: Email:  |
|  | **School/Educational offer** | Name of school: Address of school: Named contact:  |
|  | **Diagnosis**(Please include the details of your/your child’s physical health, mental health, and any conditions) |  |
|  | **Previous relevant medical history** |  |
|  | **Current support**(Please include all support you/your child currently receives i.e., from mental health services, learning disability services, social care support, school support) |  |
|  | **Annual health check**(Please include the date of your/your child’s last annual health check if over 14 years old) |  |
|  | **Date of last psychiatry review**(If applicable) |  |
|  | **Medication**(Please list all medications you/your child takes, including any recent changes in medication) |  |
|  | **Mental health detentions (inc. S117)**(Please include the dates of any detentions under the Mental Health Act and the corresponding section details. If applicable, please include any dates/details where you/your child were discharged under Section 117 aftercare) |  |
|  | **Social care information**(Please tick the relevant details if applicable) | Child in need Child protection Deprivation of Liberty Looked after child Safeguarding concernsOther | ☐☐☐☐☐☐ |
| If other, please explain:  |
|  | **Reason for self-referral**(Please include the reason you are self-referring yourself/your child to be considered for inclusion on the DSR. Please include any recent significant life events) |  |
|  | **Any other information** (Please include any information that you feel may be important i.e., being known to the criminal justice system or history of drug or alcohol service involvment) |  |
|  | **If you have completed this form on behalf of a child, please include your details** | Name: Relationship to child: Address: Telephone:Email:  |

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**Consent Form**

**4**

**4**

I acknowledge, that if I am to be added to the DSR, I/my family will be offered support from a Navigator who will work with us to get to know us and to identify what we, as a family might need help and support with (Appendix 2).

**3**

**2**

**1**

I (or if I am under 16, my Parent/Guardian/Next of Kin) has read Appendix 1 (information about the Dynamic Support Register, known as the DSR).

I agree to appropriate information being shared with Health, Education & Social Care to enable me/my child to be safely supported.

I (or if I am under 16, my Parent/Guardian/Next of Kin) give consent (or a Best Interest decision has been made on my behalf) for me/my child to be considered for inclusion on the DSR.

|  |  |
| --- | --- |
| **Name** |  |
| **Date of birth** |  |
| **Parent/Carer Name** |  |
| **Relationship to young person** |  |
| **Signature** |  |
| **Date** |  |
| **OR** |  |
| **\*Best Interest Decision made by:** |
| **Name** |  |
| **Signature** |  |
| **Date** |  |

*\*please provide details of a Best Interest discussion in line with the Mental Capacity Act 2005, including the date and details of a formal Capacity Assessment.*

**Submission**

**If you/your child is aged 0-17, please submit your completed referral form and consent form to:** **nwicb.cypm@nhs.net**

**If you are aged 18 or over, please submit your completed referral form and consent form to:** **nwicb.ippteam@nhs.net**

**Appendix 1**

Dynamic Support Register (DSR) Information Sheet:

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Dynamic Support Register (DSR) Information Sheet - Easy Read:

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**Appendix 2**

Transforming Care Navigators Information Flyer:

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Transforming Care Navigators Information Flyer – Easy Read:

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*Under Article 7(3), GDPR ensures that* ***you have the right to withdraw your consent at any time****. Should you wish to withdraw your consent for being placed on the Dynamic Support Register (DSR), please inform us via email at* *nwicb.cypm@nhs.net**.*