Early Help Team

Disability 0-25

Referral Form

Before making a referral to the Early Help Team, please consider the following definition of a Disability under Families First guidance:

The Equality Act 2010, Section 6.1 defines disability a person who has a disability if:

(a) The person has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on person's ability to carry out normal day-to-day activities

Consent

Personal information processed by Carmarthenshire County Council is done so in accordance with Data Protection legislation. Your information will be kept secure at all times and only used with your full knowledge and consent. In certain circumstances Carmarthenshire County Council may be required to share your information without your consent, for example where legally required to do so to protect an individuals' safety, or to prevent fraud etc.

Carmarthenshire County Council will use the information contained within this form for the purpose of delivering the service to you. This may involve sharing your information with partner organisations to do so.

If you would like further information about how the Early Help Service is delivered or have any specific queries in relation to how your information is processed, please contact the team on: DisabilityReferrals@Carmarthenshire.gov.uk

I confirm that I have read and understood the information contained within this form and consent to Carmarthenshire County Council processing my information for the purpose of delivering the service to me/my family.

State if verbal consent

Signed (Parent/Carer) (if applicable)	Print Name	Date
Signed (Child,Young Person, adult) if applicable)	Print Name	Date

(Please complete this form fully. Missing information will delay referral)

Child/Young Person's Details

Date of Referral				
Name of Child/Young Person			**Date of Birth/EDD:**	
Ethnicity			**Carefirst Number (if applicable)**	
Main address including post code				
Do you /they have a health passport?				
Who should we contact first? **(parent/carer, yourself, young person)** **Please details below of the number/email to contact?**				
Home Number				
Mobile Number				
Email				
Do you/they have transport?				
Home (e.g living with parents/independent **Supported accommodation)**				
Is the young person/you in Employment, Education or Training?				
Parents/Carers (if applicable)	**Name**	**Relationship**	**DOB**	**Employment Status**

Siblings (if applicable)	Name	DOB	School
Other useful contacts (important people in their lives – e.g Aunty)	Name	Relationship	Contact Details

Other Professionals involved			
	Name and Address:	Telephone Number:	Email Address:
GP / Surgery			
Midwife (if app)			
Health Visitor (if app)			
School Health Nurse (if app)			
Social Worker			
Childcare / School (if app)			
Others (please state)			

Person Referring – please note you can self refer

Name	
Address	
Contact phone no	
Email address	
Job Title / Role (if applicable)	
Agency (if applicable)	

Known Disability **If yes, please state known condition:**	**YES / NO** **DIAGNOSED / UNDIAGNOSED**
What are the main impacts of the/your disability?	

What previous support has been received? *Please supply details*	
What current support is in place? *Please provide details*	
What referrals for support have been made? *Please detail and attach any support or care plans.* *e.g. Flying Start / SALT / OT/IAS/Iechyd Da*	

What specific support would be of benefit? **(please complete as appropriate)**	**Developmental Play** **YES / NO** **Pre-School support.** **YES / NO** **Continence / Sleep**: **YES / NO** *Any referrals for sleep, continence, weaning and diet, need to have been addressed by the Health visitor or School Nurse beforehand. Please attach the Care Plan, identifying how long it has been tried, what's worked, what hasn't worked, and when it was reviewed.* **Behaviour Management:** **YES / NO** *If school have a behaviour management plan, transfer that to home environment before referring. If it doesn't work, please attach it.* **Anxiety Management.** **YES / NO** **Sensory Support** **YES / NO** **Parenting Support Group** **YES / NO** **Autism spectrum disorder support** **YES / NO** What other support would be of benefit to the young person/family? Please give further details below.
What are the views / wishes of the child, young person or adult/representative?	

Has a JAFF or another assessment already been completed? **YES / NO**

If they answer is yes, please ensure this is sent with the referral.

Please email this referral form or send to:

disabilityreferrals@carmarthenshire.gov.uk

or

Early Help Team, St Anne's Building, Parc Dewi Sant, Job's Well Road, Carmarthen SA31 3HB