**Insight SBS Ltd Referral Form**

*Insight Specialist Behavioural Service supports adults with intellectual disabilities and additional behaviours which challenging. Support is provided by the service to enhance opportunities for meaningful and rewarding lives, in conjunction with reduction in challenging behaviours. All of Insight’s services are located within community settings, supporting and encouraging inclusion within the local community. Insight thrives to support the people living within the service using a holistic approach and works to reduce challenging behaviours to improve quality of life- through the implementation person centred active support, positive behaviour support and applied behaviour analysis. Insight is transparent in all aspects of its business and provision of care and always works to maintain the safety of the users of service.*

**Return Completed forms to:**

Insight SBS Ltd Tel : 01795 424823

Aspley House, 204 Email:

London Road

Sittingbourne

ME10 1QA

For Insight use only:

Date received: Received by:

Funding agreed by CCG: Yes No

Date off assessment: Assessors:

Referral Accepted: Declined: Waiting List:

|  |
| --- |
|  **People informed of decision** |
| **Referrer:**  |  | **Date:**  |  | **Informed by:** |  |
| **Service User:** |  | **Date:** |  | **Informed by:** |  |
| **NOK:** |  |  |  | **Informed by:** |  |
| **GP:** |  | **Date:** |  | **Informed by:** |  |
| **Carer/Key worker:**  |  | **Date:** |  | **Informed by:** |  |
| **Care Manager:** |  | **Date:**  |  | **Informed by:** |  |
| **Other:** |  | **Date:**  |  | **Informed by:** |  |

**Responsible CCG:**

**The Referrer**

|  |  |
| --- | --- |
| **Name:**  | **Occupation:** |
| **Address:** **Signature:** **Date:**  | **Tel.:** **Email:**  |
| **Reason for Referral** |
|  |

**Service User Information**

|  |  |
| --- | --- |
| **Title:** **Forename(s):** **Surname(s):** **Alternative name(s):**  | **DOB: Age:****Gender: Diagnosis:** **NHS no:** |
| **Present Address:** **Contact Name:** **Contact no:** **Length of time at present address:**  | **Home address:** **Contact name:** **Contact no:** **Length of time at this address:**  |
| **White** British Irish Any other white background | **Asian or British Asian** Indian Pakistani Bangladeshi Any other Asian background |
|  **Black or Black British** Caribbean African Any other black background | **Other ethnic groups** Chinese European Any other ethnic group Mixed ethnic group specify  |

**Capacity Around Moving to a New Home**

1: Does the person have an impairment of the mind or brain at the time of assessment, or is there some sort of disturbance affecting the way their mind or brain works? Yes  No 

2: Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? Yes  No 

Can the person:

1. Understand the information relevant to the decision? Yes  No 
2. Retain that information? Yes  No 
3. Use or weigh that information as part of the process of Yes  No 

making the decision?

1. Communicate his/her decision in any way? Yes  No 

(NB: If a person cannot do one or more of these four things, they are unable to make the decision)

**Outcome of Mental Capacity Assessment**

On the balance of probabilities, there is a reasonable belief that:

The person has capacity to make this particular decision at this time Yes  No 

Or

The person does not have capacity to make this particular decision Yes  No 

at this time

**Details of Assessor**

Name: Signature: Occupation:

Date: Time:

**Best interest meeting**

Has the person had a best interest meeting regarding a move Yes  No 

to their new home?

|  |  |
| --- | --- |
| NOK: Relationship: Contact Details: Are they aware of referral? Yes No  | Care Manager: Email Address: Contact Number:Are they aware of referral? Yes No |
| Registered GP: Address: Tel no: Are they aware of referral? Yes No | Responsible Consultant: Email Address: Contact Number: Are they aware of referral? Yes No |
| Psychologist: Email Address: Contact Number: Are they aware of referral?Yes No | Community Nurse: Email address: Contact Number: Are they aware of the referral? Yes No |
| **Reason for referral:**  |
| **Service Users Preferences:**  |
| **Primary Needs:**  |
| **Challenging Behaviours Presented:** Frequency: Duration: Known Triggers:Consequences:  |
| **Current accommodation and current support levels:**  |
| **Current medication:** *Any allergies or sensitivities to medications:* |
| **Other significant information about the individual:**  |