

REFERRAL FORM

**ARCS**

**AUTISM AND DISABILITY SERVICE**

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# REFERRAL AND ADMISSIONS PROCEDURE

## Admissions to the Designated Centre:

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| --- | --- |
| **Registered Bed Numbers:** | Our Residential Services will provide for a maximum of 3 / 4 residents at any one time. |
| **Age range of residents to be accommodated:** | Or Residential will provide for residents aged 18 or younger |
| **Gender of residents to be accommodated:** | Our Residential Services will provide inclusively for all genders. |

### Criteria used for determining admission:

The following general criteria must be met in order to secure admission to ARCS Full-time / Shared Care services:

* The applicant must be a person with a diagnosis of ASD, Intellectual Disability or other Pervasive Developmental Disorder
* A suitable vacancy must be available in the service requested;
* The Admissions Committee must agree that the needs of the applicant can be met in the service requested;
* The necessary resources as may be reasonably necessary to meet any additional disabilities and/or complex needs must be in place.

### Specific Criteria for Admission applicable to people with specific support needs:

With certain applications, decisions regarding admission will only be made by the Referral Committee upon the availability of adequate resources and an appropriate environment.

### Admission Documentation

If the applicant is deemed suitable for admission, the following forms must be completed by the applicant, or parent/ guardian/designated representative and returned to the ARCS Referral Committee Ireland prior to admission and in any event within 21 days of such form (s) issuing:

* Application for Admission to Services;
* Consent form: Request for Specialist Reports;
* Medical Report;
* Hepatitis B Immunisation Programme;
* Authorisation & Consent for Emergency Medical or Surgical Treatment;
* Service Contract/ Terms & Conditions;
* Consent to data processing form;
* HSE Financial Assessment form (where applicable).

The person in charge of each designated area shall ensure that each prospective person to be supported and or their parent(s), guardian or designated representative are provided with an opportunity to visit the designated centre, as far as is practicable, before admission.

ARCS, on admission, agree in writing with each person wishing to access its services and/or parent(s), guardian or designated representative where the person is not capable of giving consent, the terms on which that person shall attend the designated area.

### Pre-admission:

ARCS are committed to the smooth transitions of service users and parents/guardians/carers into the service. Transitioning should be a positive experience as it lays the foundation for successful service engagement. Transitions are a collaborative process between parents/guardians/carers, referral agent, staff and service user. Family involvement (where possible) will be encouraged to assist all service users to develop secure relationships with the staff team.

# POLICY FOR EMERGENCY ADMISSIONS:

It is the belief of ARCS that admissions into our services benefit from planning and solid transitions, however ARCS recognises that there may be circumstances where the immediate welfare of an individual may be at risk and therefore a need for emergency admission may exist.

As per policy all requests for emergency admission are to be made via our Assistant Director of Disability Services

Consideration will be made following the completion of a pre-admission collective risk assessment which will be completed in conjunction with the referral party/ ADOS/ PIC.

* The impact will look at:
* Medication, physical, mental health of the individual.
* Risks to a new service user.
* Risks of new service user on existing service users (Pre-admission Impact Risk Assessment).

The MD will co-ordinate a meeting with the referral team, a plan will be developed in response to the impact risk assessment and from here it will be deemed if admission is appropriate to the needs presented.

# REFERRAL FORM

|  |  |
| --- | --- |
| **Service being requested through referral** | **Please tick as appropriate** |
| Residential Service |  |
| Outreach / Respite Service |  |
| Shared Care Service |  |
| Emergency Placement |  |
| \*\*In the event that an overnight placement is not immediately available would  community outreach be of some assistance: |  |

|  |  |
| --- | --- |
| **Details of Referral Agent:** |  |
| **Name** |  |
| **Contact Number** |  |
| **Contact Address** |  |
| **Relationship to Individual being referred** |  |
| **Other relevant information** |  |

|  |  |
| --- | --- |
| **Details of Individual Being referred** | **Fill out in as much detail as possible** |
| **Name:** |  |
| **Date of Birth:** |  |
| **Residing Address:** |  |
| **Primary Carer(s) name and contact details:** |  |
| **Primary Diagnosis:** |  |
| **Secondary Diagnosis (if applicable):** |  |

|  |  |
| --- | --- |
| **Current support services – e.g. family supports, other professionals**  **involved with young person’s care):** |  |
| **Primary Reason for Referral:** |  |
| **Significant event which may have contributed to referral:** |  |
| **Other relevant information:** |  |

# PRE-ADMISSION COLLECTIVE RISK ASSESSMENT

\*\*Tick below the relevant behaviours and detail, where possible, risk associated with same

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Presenting Behaviours** | **Yes/No** | **Description of risk** | **Risk Level** | **Frequency** | **Potential impact of identified risk on current group if applicable.** | **Potential impact of identified risk on potential resident from the current group if applicable.** |
| **Absconding/ Running Away** |  |  |  |  |  |  |
| **Aggression towards adults and peers** |  |  |  |  |  |  |
| **Self-injurious behaviour** |  |  |  |  |  |  |
| **Anti-Social Behaviour** |  |  |  |  |  |  |
| **Bullying** |  |  |  |  |  |  |
| **Defiance/ Non- Cooperation** |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Damage to Property** |  |  |  |  |  |  |
| **Disruptive Behaviour** |  |  |  |  |  |  |
| **Frequently Tells Lies** |  |  |  |  |  |  |
| **Intimidating Behaviour** |  |  |  |  |  |  |
| **Poses Child Protection Risk** |  |  |  |  |  |  |
| **Risk Taking Behaviour** |  |  |  |  |  |  |
| **School Refusal** |  |  |  |  |  |  |
| **Sexualised Behaviour** |  |  |  |  |  |  |
| **Sexually Active** |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Smearing** |  |  |  |  |  |  |
| **Stealing/ Criminal behaviour** |  |  |  |  |  |  |
| **Violence towards adults or other young people** |  |  |  |  |  |  |

## Vulnerabilities Risk Assessment

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| --- | --- | --- | --- | --- | --- | --- |
| **Vulnerabilities Presenting** | **Yes/No** | **Description of risk** | **Risk Level** | **Frequency** | **Potential impact of identified risk on current group if applicable.** | **Potential impact of identified risk on potential resident from the current group if applicable.** |
| **Difficulty Sleeping/ Settling at Night** |  |  |  |  |  |  |
| **Easily Led** |  |  |  |  |  |  |
| **Encopresis/ Enuresis** |  |  |  |  |  |  |

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| **Issues with Food/ Body Image** |  |  |  |  |  |  |
| **Learning Difficulty** |  |  |  |  |  |  |
| **Assessed Psychological Disorder** |  |  |  |  |  |  |
| **Diagnosed Psychiatric Condition** |  |  |  |  |  |  |
| **Physical Disability** |  |  |  |  |  |  |
| **Poor Personal Hygiene** |  |  |  |  |  |  |
| **Self-Harming Behaviours** |  |  |  |  |  |  |
| **Sensitive to Chaos/ Instability** |  |  |  |  |  |  |
| **Suicide Attempts/ Concerns** |  |  |  |  |  |  |
| **Vulnerable to Bullying** |  |  |  |  |  |  |

# DEVELOPMENTAL NEEDS/ SUPPORTS/ HEALTH

## Medical Needs

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Health Development:** | | **Diagnosis:** | | | |
| **Current Diagnosis and Medical Summary:** |  | | | | |
| **Medical Needs:** | | | | | |
| **Include Details of Individual Mental Health Status (attach supporting documentation if available)** |  | | | | |
| **Medication:** | | | | | |
| **List Current Medication** |  | | | | |
| **Name of Drug** | | **Dosage** | **Frequency** |  |
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#### Other Relevant Information;

# PHYSICAL NEEDS AND DEVELOPMENT

|  |  |
| --- | --- |
| **Physical Development:** | **Physical Disability:** |
| **Detail Controls Currently in Place and Controls Needed:** |  |
| **Mobility:** | |
| **Detail Controls Currently in Place and Controls Needed:** |  |
| **Specialised Equipment:** | |
| **Detail Controls Currently in Place and Controls Needed:** |  |

|  |  |
| --- | --- |
| **Special Environmental Adaptations:** | |
| **Detail Controls Currently in Place and Controls Needed:** |  |
| **Diet:** | **Specialised Dietary Requirements:** |
| **Detail Controls Currently in Place and Controls Needed:** |  |
| **Daily Diet:** | |
| **Detail Controls Currently in Place and Controls Needed:** |  |
| **General Relationship With Food:** | |
| **Detail Controls Currently in Place and Controls Needed:** |  |

Please return the completed referral form to:

[callie@a-rcs.ie](mailto:callie@a-rcs.ie)

or alternatively post to:

#### Callie Kennedy

ARCS

Graigue Clogheen Co. Tipperary E21 F832

Should you have any queries pertaining to our services or referral processes please don’t hesitate to contact us:

#### Callie Kennedy

Assistant Director of Disability Services 083-3444305

[info@a-rcs.ie](mailto:info@a-rcs.ie)