**South Tyneside CCG –**

**Community Care and Treatment Review / Care Education Treatment Review / MDT+**

**Request Form**

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| Please return the completed form to Your Voice Counts on yvc.uk@nhs.net (0191 478 6472) |
| Name of Person: |  | Gender: | M |  | F |  | Date of Birth: |  |
| Current address (including postcode): |  |
| Usual address (if different): |
| Contact number: |   | E-mail: |  |
| Date of referral: |  | Type of Review | CTR |  | CETR |  |
| Is there significant risk of current placement breakdown and hospital admission? If so, why? |  |
| Has there been a MDT to discuss the above? If yes, what was the outcome of this meeting? |  |
| Has a MDT+ been considered? |  |
| Does the person have an advocate who can support them to prepare for the meeting, to attend with them if this is what they want, or to attend on their behalf if they are unable or unwilling to attend? If YES, please include contact details on attendee list below.  |  |
| If the person does not have an advocate, Your Voice Counts can provide this support. Do you want to make a referral for a YVC advocate? |  |
| **People who should be there:** *indicate the people who need to be invited to the CTR/CETR including family/carers/advocate.* ***Please include both an email address and contact number when completing the form*** |
| **Full Name** | **Position/Role** | **E-mail Address** | **Contact number** | **State Preference** |
|  | The person |  |  | Optional/Essential |
|  | Family member |  |  | Optional/Essential |
|  | Social Worker |  |  | Optional/Essential |
|  | Service provider |  |  | Optional/Essential |
|  | Advocate  |  |  | Optional/Essential |
|  | Community Team |  |  | Optional/Essential |
|  | Doctor/ Consultant |  |  | Optional/Essential |
|  | Doctor/ Consultant Secretary |  |  | Optional/Essential |
|  | Named key nurse |  |  | Optional/Essential |
|  | Named key worker |  |  | Optional/Essential |
| **Preferred date and time of Review (please provide at least two options, and ensure the proposed time allows panel members at least one hour to prepare prior to the review):**  |
| Option 1 | Option 2 |
| Date:Time: | Date: Time: |
| Alternative(s): |
| Preferred venue/virtual meeting (full address, if not recorded above, and any access requirements): |
| Additional requirements:  |
| Has the person consented to the CTR/CETR request? | Yes |  | NO |  |
| If the person does not have the capacity to consent, please provide evidence of the decision by the MDT that it is in the person’s best interest to proceed. Include the date of the MDT. |
| How is the Person’s package of support currently funded *(please select all that apply)?* |
| CHC |  | Section 117 |  | Local Authority |  |
| Completed by (signature): | Print name: |
| Role: | Date: |
| **General Data Protection Regulations Statement**Your Voice Counts is committed to processing information in accordance with the General Data Protection Regulation (GDPR). The personal data collected on this form will be held securely and will only be used for the purposes of organising a MDT+/CTR/CETR. You can use the below contact details if you have any questions about this form, the way we are planning to use the information on the form, the lawful basis for processing the information on the form, or any queries relating to data protection. **Contact details** Jenny Rohde (Operations Manager) jenny.rohde@yvc.org.uk **Complaints** You have the right to lodge a complaint against Your Voice Counts regarding data protection issues with the Information Commissioner’s Office (https://ico.org.uk/concerns).  |
| **Service User Pen Picture** |
| To be returned to Your Voice Counts yvc.uk@nhs.net (0191 478 6472) with the completed review request; this will be shared with the Panel **ONLY** in preparation for the CTR/CETR |
| *Please ensure only initials are used within the Pen Picture, and the following points are covered within the narrative:** Age
* Family/home situation including marital status/children
* Important people
* Employment / vocational activities
* Likes / dislikes
* Diagnosis / Co-morbidities
* Views of the person
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| Situation  | * What are the current difficulties /issues causing concern?
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| Background | * Diagnosis, history, previous admissions over the last 12 months that may be relevant.
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| Assessment | * Mental state and Capacity.
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| Formulation  | * Is there a recent formulation?
* What is the current understanding of the difficulties the person is facing?
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| Why now? | * What has changed in recent weeks that have negatively impacted upon the person?
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| Person’s preferred method of communication |
| English (spoken) |  | Other spoken language |  | Sign language  |  |
| Gestures/facial expressions  |  | Pictures/Makaton |  | No obvious means |  |
| Other (please state): |  |

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| **ETHNIC BACKGROUND** *(Please tick box that applies)* |
| White British |  | Black or Black British ‐ African |  |
| White Irish |  | Black or Black British ‐ Caribbean |  |
| White ‐ Gypsy or Irish Traveller |  | Black or Black British ‐ Other |  |
| White – any other White background |  | Asian or Asian British ‐ Bangladeshi |  |
| Mixed: White \ Black Caribbean |  | Asian or Asian British ‐ Indian |  |
| Mixed: White \ Asian |  | Asian or Asian British ‐ Pakistani |  |
| Mixed: (Other Background) |  | Asian or Asian British ‐ Other |  |
| Mixed: White \ Black African  |  | Asian or Asian British -Chinese |  |
| Mixed: White \ Black African |  | Other Ethnic Groups |  |
| Mixed ‐ White and Black Caribbean |  | Not Specified / Unknown |  |
| Mixed ‐ Other |  |  |
| **Any identified religious, cultural or spiritual needs?** |  |

**For office use only**

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| Type of Review | MDT+ |  | CTR |  | CETR |  |