**Referral Form  
Learning Disability Service - Single Point of Access**

**Please complete all sections; failure to do so may delay/prevent your referral being processed. If you are unsure whether the referral is appropriate or would like support completing the form, please do not hesitate to contact the Advice and Contact team on 0300 456 0111 (ask for the Learning Disability Health Team) or email** [**whc.ctpldreferrals@nhs.net**](mailto:whc.ctpldreferrals@nhs.net)

**Icon

Description automatically generated Please note we do not provide emergency/urgent services Icon

Description automatically generated**

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| **Date of Referral:** |

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| **A red brick building with windows  Description automatically generated with low confidence** **Details of Referred Person** | |
| Name: (Including title) | [Full Name] |
| Current address: |  |
| Telephone: Mobile:  Landline: |  |
| Date of Birth: | [Date of Birth] |
| NHS No. | [NHS Number] |
| Ethnicity: |  |
| Nationality: |  |
| Religion: |  |
| Occupation: |  |
| Employment Status: |  |

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| **Consent**  **If this is not complete, we will be unable to process this referral.** |  |
| Is the referred person aware of the referral? | Yes  No |
| Does the person have the capacity to consent to the referral? | Yes  No |
| Has the person consented to the referral? | Yes  No |
| Has the referral been made in the person’s best interest? | Yes  No |
| **Eligibility for Learning Disabilities Services Please tick all that apply** *(Please note, selection of criteria below does not indicate whether the referral will be accepted or declined but will provide a clearer indication of the person’s abilities/support needs)* | | |
| Evidence of a formal Learning Disability Assessment (WAIS, IQ testing)  Under the care of a consultant psychiatrist for learning disabilities  Needs support with activities of daily living  Specialist Schooling or statemented in mainstream school  Previous involvement from Learning Disability Services  Has/had an Education, Health and Care (EHC) Plan (Please remember that an  EHCP maybe for behaviour and emotional difficulties/physical disabilities)  The person has academic qualifications? (ie GCSE, BTEC, A-Level etc.)  Other/further information (please specify)  Are they on the Learning Disability Register with their GP Practice? Yes  No  Unknown | | |

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| **Communication** |
| **What is the person’s main communication method?**  **Please select all other communication methods used:**  Verbal (Speech)  Makaton/Signing  Objects of Reference  PECS (Picture Exchange Communication System)   Tablet/Computer  Body Language (e.g. pointing, gestures, facial expressions)  Eye Gaze   Other - Please Specify: |

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| **Reason for Referral**  **Please explain what prompted you to make this referral?  What are the HEALTH needs?** |
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| **What has been done/tried so far?** |
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| **Goal: What do you hope for as a result of this referral?** |
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| **Health Conditions**  **Please list** | **Medication**  **Please list (include dosage if able)** |
|  |  |
| Date of last Annual Health Check: | |

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| See the source image**Risk Please select all that apply** | |
| Risk to self (injury, neglect)  Risk from others  Risk to others  Placement risk  Physical health decline  Falls risk  Choking risk  Epilepsy/Seizures risks  Any current drug or alcohol use | |
| Please give details below: | |
| **Support** | **Accommodation** |
| None  Unpaid carers  Paid carers (please specify provider) | Nursing Home  Residential Home  Supported Living Shared Lives  Lives with Family  Lives alone   Other (please specify) |
| **My support**  All activities of daily living  Access to health care  Medication  Personal care  Domestic tasks  Mobility  Community Access  Finances  Reading and writing |

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| **Referrer** | |
| Name |  |
| Relationship |  |
| Address |  |
| Telephone (Mobile/Landline) |  |
| Email |  |
| Availability |  |

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| **General Practitioner** | |
| Doctor Name |  |
| Surgery |  |
| Address |  |
| Telephone (Mobile/Landline) |  |

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| **Next of Kin** | |
| Name |  |
| Relationship |  |
| Address |  |
| Telephone (Mobile/Landline) |  |
| Email |  |

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| **Appropriate person to contact for more information (if different to the Referrer above)** | |
| Name |  |
| Relationship |  |
| Address |  |
| Telephone (Mobile/Landline) |  |
| Email |  |
| Availability |  |
| Has the referred person given their consent for us to contact this person? | Yes  No  If no who can we contact with consent? |

To avoid any delay in your referral, please send by email to [whc.ctpldreferrals@nhs.net](mailto:whc.ctpldreferrals@nhs.net)