**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**

** Please note we do not provide emergency/urgent services **

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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 ServicesPlease 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)** |
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| Date of last Annual Health Check: |

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| See the source image**RiskPlease 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