**REFERRAL FORM**

**Adult Community Team for Learning Disabilities**

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| **Referral and criteria information**  **Criteria for access to the Learning Disability Service is a diagnosed learning disability as defined below:** |
| **A Learning Disability / Intellectual Disability is:**   * **A significantly reduced ability to understand new or complex information, with a reduced intellectual ability.** * **A reduced ability to cope independently (impaired social functioning). This includes difficulties with everyday activities – for example household tasks, socialising or managing money.** * **Present before adulthood (must have these difficulties before 18 years old)**   **A learning *disability* is often confused with learning *difficulties* such as Dyslexia, ADHD, Autism (without a learning disability) or Dyspraxia.**  **Please note that we do not provide a standalone diagnostic service for learning disability.** |

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**Please complete all sections**

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| **Date of referral:** | | | | **Date referral received:**  **(To be completed by CTLD)** | | | | |
| **Section 1: Details of person being referred.** | | | | | | | | |
| Name: | NHS Number: | | | | | | Date of birth: | |
| **Male/ female/ non-binary/ prefer not to say:** | | | | | | | | |
| **Address:**  **Telephone/Mobile:** | | | | | | | | |
| **Ethnicity:** | | | | | | | | |
| **Section 2: Name of emergency contact** | | | | | | | | |
| Name: | | | | Relationship to referred person: | | | | |
| Address: | | | |  | | | | |
| **Section 3: General health information** | | | | | | | | |
| GP Practice Name:  Doctor:  Address:  Telephone/Mobile: | | | | | | | | |
| **Date of last annual health check:** | |  | | | | | | |
| **Section 4: Referrer details** | | | | | | | | |
| Name of referrer: | | | | Relationship to referred person: | | | | |
| Address: | | | | | | | | |
| **Signature of referrer:** | | | | **Date:** | | | | |
| **Section 5: Why are you making the Referral?** | | | | | | | | |
| **Please give details of the reasons why you think the person needs support from the Adult Learning Disability Team. The person should have a specific health need which cannot be met by mainstream services alone.** | | | | | | | | |
| **Section 6: Risk Assessment** | | | | | | | | |
| **Things to consider when visiting:**  **Environmental risks (pets, obstacles, access, parking, access)** | | | | | | | | |
| How does the person communicate? (Verbal, pictorial, with support etc.) | | | | | | | | |
| **Interpreter needed yes or no?**  What Language? | | | | | | | | |
| Are there any medical alerts, allergies, adverse reactions? | | | Yes No | | Details: | | | |
| Safeguarding concerns? (e.g., legal proceedings, child protection, Police involvement) | | | Yes  No | | Details: | | | |
| **Section 7: Learning Disability Screening:** | | | | | | | | |
| **Does the person have a diagnosis of a learning disability?**  If yes please provide details | | | | | | | |  |
| **Does the person have a syndrome which relates to a learning disability?**  If yes please provide details | | | | | | | |  |
| **Has a cognitive assessment & or adaptive living skills been completed?**  If yes please attach a copy | | | | | | | |  |
| **Has the person been known to Learning Disability Services before?**  If yes please give details | | | | | | | |  |
| **Does the person receive a funded package of care?**  Is this CHC or local authority?  Please provide details of care package & name of funding authority | | | | | | | |  |
| **Does the person have an EHCP (Education Health Care Plan)**  If yes please attach a copy | | | | | | | |  |
| **Section 8: Consent to referral**  ***PLEASE NOTE IF CONSENT / BEST INTEREST IS NOT COMPLETED THIS MAY DELAY THE REFERRAL PROCESS*** | | | | | | | | |
| Capacity to consent.  I consent to this referral being made. | | | | | |  | | |
| Client has capacity to consent but is unable to sign.  Please give reasons why. | | | | | |  | | |
| Client does not have capacity to consent.  Referral in the person’s Best Interests? | | | | | | **Who made decision & when?** | | |
| **Section 9: Support network** | | | | | | | | |
| Include name of;  Family members,  Staff, managers,  Social worker  Psychiatrist  Neurologist or other consultant  Main carer  Other health professional  Any other professionals involved: | | | | Contact details: | | | | |

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| **Section 10: Any other relevant information** |
| Please provide any relevant information not captured in other sections, attach any reports / letters from other professionals or evidence of learning disability. |
| **What will happen next?** |
| * The referral will be reviewed by the Community Team for Learning Disabilities to determine suitable criteria and priority * At this stage the case is NOT open * The referrer will be informed of the outcome   **Incomplete referral forms will be returned and this may delay allocation.** |
| **Please send the completed form to:** |
| Community Learning Disability Team (CLDT)  Pennine Care NHS Foundation Trust  Learning Disability Care Hub  2nd Floor, Stopford House  Piccadilly  Stockport  SK1 3XE  [pcn-tr.stockportctpld@nhs.net](mailto:pcn-tr.stockportctpld@nhs.net)  If you wish to discuss this referral please ring 0161 716 5520 |