**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 workerPsychiatristNeurologist or other consultantMain carerOther health professionalAny 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 TrustLearning Disability Care Hub2nd Floor, Stopford HousePiccadillyStockportSK1 3XEpcn-tr.stockportctpld@nhs.netIf you wish to discuss this referral please ring 0161 716 5520 |