

Return completed forms to:

Learning Disability Access Team

138 Winstanley Drive

Leicester

LE3 1PB

Tel: 0116 295 4528

Email: lpt.ldaccess@nhs.net

LEARNING DISABILITIES SERVICE (HEALTH)

##### REFERRAL FORM

**Confidentiality:** People have a right to access information about themselves. Please advise the person you are referring that the information you give could be shared with other members of the Healthcare Team in order to give them the most appropriate services but that they have a right to withhold their consent. During the course of their care some information may be recorded on computers. For their protection, the use of this data is controlled in accordance with the Data Protection Act (2018).

**Referral Criteria**

A learning disability is defined by the Department of Health as a “significant reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood”.

**Eligibility Criteria:**

* The patient has a **significant learning disability** and is aged 18 or over
* The patient has health difficulties which are critical or substantial in nature and that cannot be fully met via mainstream services
* The patient has complex health needs.

**Exclusion Criteria (unless there is a learning disability)**

* Dyslexia
* Dyspraxia
* Hyperactivity Attention Deficit Disorder (ADHD)
* Autism

**If you would like to discuss your referral first, please contact the Learning Disability Access Team on 0116 295 4528.**

**Has the person referred got a diagnosis of learning disability? *please tick*  YES   NO**

**If No, Why do you suspect a learning disability? Please give evidence below:**

**NB: If key information is not competed the referral may be returned and not progressed**

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| **Date of Referral** |  | | | **NHS No:** | | | |  | | |
| **Referred person:** | | | | | | | | | | |
| **Surname** | | **Forename(s)** | | | **DOB** | | **M/F** | | **Mental Health Act (MHA) Status** (if applicable) | |
|  | |  | | |  | |  | |  | |
| **Ethnic Origin** |  | | **Religion** | | |  | **Marital Status** | | |  |
| **Main Language** |  | | **Interpreter Needed** | | | ***❑ Yes ❑ No*** | | | | |
| **Main Address** |  | | | | **GP Address** | |  | | | |
| **Type of Accommodation?** | | | | **Is GP Aware of referral: Y / N** | | | |
| **Tel no:** |  | | | | **GP Tel No:** | |  | | | |
| **NB The registered GP must be part of a Leicester, Leicestershire or Rutland CCG practice for the referral to be accepted** | | | | | | | | | | |

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| **Funding – who funds support received by this person e.g. CHC, Social Care, S117** |

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| **Details of Next of Kin/Carers including the person they live with and who is responsible for their care?** | | | | | | | | | |
| **Does the person have an independent advocate? *❑ Yes ❑ No If yes include their details below.*** | | | | | | | | | |
| **Full Name** | | **Contact Number** | | **Relationship to Client/ patient** | | | **Address if different to the clients** | | |
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| **Who is the best person to contact regarding the referral to gather pre assessment information?**  C:\Users\williamsze\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\T3QO4WQU\medium-Tick-Mark-Check-Correct-Choose-Accurate-166.6-13398[1].gifTick where appropriate and provide details below | | | | | | | | | |
| Patient | | | Next of Kin | | Main Carer | | | Other Professional | |
| **Are there any legal arrangements in place that the service need to be aware of? If yes please tell us what these are:** | | | | | | | | | |
| **Referrer Details** | | | | | | | | | |
| **Name** |  | | | | | **Telephone Number** | | |  |
| **Relationship to Patient** |  | | | | |
| **Address** |  | | | | | | | | |

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| **Consent NB consent or a best interest’s decision must be confirmed for the referral to be accepted** |
| **Is the Patient is able to make informed consent and has consented to the referral? Y / N**  **If NO, has best interest been considered: Y / N**  **Details:** |
| **Reason for Referral:** |
| * **What has prompted you to make this referral now?** * **Please describe the current health situation, when it started including any recent changes/ life events that have occurred in the person’s life:** * **How has this impacted on both the patient, their family or carer?** * **What improvement(s) would you expect to see as a result of this referral?** * **Has this client been seen by the service in the past Y/N/ Don’t know**   **Does the person present with any of the following? Tick any that apply.**   |  |  | | --- | --- | |  | **Challenging Behaviour /Positive Behaviour Support** | |  | **Difficulties eating and drinking safely** | |  | **Complex Physical Health needs** | |  | **Sensory impairment** | |  | **Forensic risks** | |  | **Drug and/ or alcohol, substance misuse** | |  | **Autistic Spectrum Disorder (ASD)** | |  | **Mental Health** | |  | **Epilepsy** | |  | **Dementia/ cognitive decline** | |  | **Other, give details.** | |  | |
| **Risks including Safeguarding** |
| |  |  | | --- | --- | | **Are there any current safeguarding concerns: Y / N** | | | **Details:** |  | |
| **Any risks known or reported when working with this person – this includes risk to the person themselves. Please give details:**  **Communication Issues:  Yes  No**  **Details:**  **Family or Friends:  Yes  No**  **Details:**  **Forensic / Police History:  Yes  No**  **Challenging Behaviour:  Yes  No**  **Physical Disability:  Yes  No**  **Home Environment:  Yes  No**  **Other (Please State):  Yes  No** |
| **Action already taken / Current plan and levels of support being offered:** |

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| **Current Professionals Involved (health, social care, private provider)** | | |
| **Name** | **Professional Role** | **Contact Details** |
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