

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 **learning disability** and is aged 18 or over
* The patient has a specialist health need that cannot be met solely in primary /secondary care 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 completed 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 ICB 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?** | | | | | | | | | |
| **Full Name** | | **Contact Number** | | **Relationship to Client/ patient** | | | **Address if different to the clients** | | |
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| **Who is the best person to complete the core 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 | |
|  | | |  | |  | | |  | |
| **Does the person have an independent advocate? *❑ Yes ❑ No If yes include their details below*** | | | | | | | | | |
| **The core assessment will be completed face to face. Are there any reasonable adjustments that need to be considered? (i.e., can the patient attend alone, would they be supported by staff/family member).**  **Or**  **Core assessment to be completed by: Next of kin ❑ Main carer ❑ Other professional ❑** | | | | | | | | | |
| **Are there any legal arrangements in place that the service needs 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 able to give informed consent and has consented to the referral? Y / N**  **If NO, has best interest been considered: Y / N**  **Details of the best interest decision and by whom:**  **Has the patient agreed to share information with family/support network? Y / N / Don’t know** |
| **Reason for Referral:** |
| * **What has prompted you to make this referral now?** * **Has the patient been reviewed in primary care/GP? Y / N / Don’t know (If yes, what was the date and outcome of this)** * **Has the patient had their LD annual health check? Y / N / Don’t know (If yes, provide date)** * **Is this referral for equipment? Y / N (If yes, provide further information and if mainstream services have been considered)** * **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**   **(If yes, have the recommendations/guidelines given at discharge been followed? Please provide information below.)**  **Does the person present with any of the following? Tick any that apply.**   |  |  | | --- | --- | |  | **Behaviours that challenge** | |  | **Difficulties eating and drinking safely** | |  | **Complex Physical Health needs** | |  | **Sensory needs** | |  | **Forensic risks** | |  | **Autistic Spectrum Disorder (ASD)** | |  | **Mental Health needs/concerns** | |  | **Epilepsy** | |  | **Dementia/ cognitive decline** | |  | **Trauma**  **Other (i.e.: sexual health, maintaining safe relationships, online safety)** | |  | |  |   **If other, please provide further information:** |
| **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**  **Behaviors that Challenge:  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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