

**Please complete all relevant sections to ensure your referral is correctly allocated.**

**\* Essential this is completed**

**ADULT LEARNING DISABILITY SERVICE SINGLE ACCESS REFERRAL FORM**

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| Our specialist community learning disability service will accept referrals for a person with the presence of a learning disability (please see below\*) with two or more of the following:* In relation to the current referral need, they have been unable to have their mental health and/or physical health needs met through mainstream service provision.
* The presence of behaviours that challenge, where the behaviour is of severity and frequency to cause significant risk to self, others or the environment, or lead to restrictive practices or exclusion.
* The service user requires an integrated specialist LD team approach to care. Other LD health professionals are involved at the same time.
* The service user’s LD is impacting on their ability to engage/comply with health need interventions.
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| * To have a learning disability the person must have all three of the issues indicated below:
* Have an intelligence quotient of below 70. They will have had great difficulties with school work and probably have attended special school.
* Have considerable and consistent difficulty in many areas of everyday life, meaning that they require practical support from others to manage in adult life.
* Have experienced the above difficulties either from birth or emerging during childhood. If difficulties do not present until the person is over 18, the person would not be considered to have a learning disability.
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| In order to prevent us asking for more information from you later or asking the person to be involved with unnecessary assessments, please provide evidence (we will return incomplete forms) for the criteria listed before we can offer an Initial Contact Assessment. |

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| **Service user details\*** |
| Surname(alias/previous name)  | Forename/s  |
| Title: | Sex: | Male |  | Female |  | Date of Birth:  |
| Address: | Town: |
| County: | Postcode: | Telephone Number: |
| Type of accommodation: | Residential care |  | Settle with family/friends |  | Supported living |  |
| Seeking housing |  | Lives alone |  | No fixed abode  |  | Other |  |
| Smoking status: | Smoker |  | Never smoked |  | Ex-smoker |  |
| Employment status: | Permanent |  | Temporary |  | Weekly hours worked |  |
| Education |  | Unemployed/disabled  |  |  |
| Language spoken by service user and principal carer(s):  | Is an interpreter required?  | Yes |  | No |  |
| **Marital status (tick relevant box)\*** |
| Single |  | Married/ civil status |  | Separated |  | Divorced |  | Widowed |  | Cohabiting  |  |
| Ethnicity:  | Religion:  |
| NHS Number:  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Service user’s General Practitioner (GP)\*** |
| Name | Surname | Surgery address: | Telephone No: |
| **Main carer details (eg family, key worker)\*** |
| Name: | Telephone Number: |
| Address: | Relationship to service user: |
| Can the carer be contacted about this referral:  | Yes |  | No |  |
| **Referral details** |
| Name of referrer: | Email address & phone number: |
| Referrer type:  | LTHT |  | LYPFT staff |  | Criminal Justice  |  | Police |  | LCH |  |
| GP |  | CAMHS/ paediatrics  |  | Transitions |  | Hospice |  | Housing |  | ASC LD |  |
| Charity |  | Out of area |  | Private hospital |  | Relative/carer |  | Social Services |  |
| SSL |  | Care management  |  | Day service |  | Respite |  | Self-referral |  | Other (specify) |  |
| Relationship to person: | Care Manager: |
| Has the service user been informed and agreed to the referral:  | Yes |  | No |  |
| Reason for referral, please detail and/or attach a letter….. |

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| **Risk (please provide information on the following areas of known risk)** |
| Yes  |  | Is the person vulnerable to risk (self neglect, physical health, physical, sexual or financial abuse)? Please give details: |
| Yes |  | Does the person pose a known risk to themselves (suicidal ideation, substance misuse, self harm)? Please give details: |
| Yes |  | Does the person pose a known risk to other people (property damage, physical harm, sexual harm)? Please give details: |
| Yes |  | Does the person pose a known risk to staff and professionals? Is a joint visit necessary? Please give details: |
| Yes |  | Does the person live in a household with children under the age of 18 years or have substantial access to their own or others children under the age of 18 years? Please give details: |
| Yes |  | Are there any known Safeguarding issues that you are aware of? Please give details: |
| **Sensory and mobility issues**  |
| Does the person have a physical disability or sensory/mobility issues? Please give details. Do they have any access problems in attending appointments? Please give details. |
| **Communication needs** |
| Does the person have any information or communication needs e.g. need information in braille, easy read, large print or via email. Please detail:  |
| **Signature (please sign and date this referral)** |
| Signed:  | Date |

**How to refer**

Referrals to our Community Learning Disability Service go through our [Single Point of Access (SPA) Team](https://www.leedsandyorkpft.nhs.uk/contact-us/urgent-referrals/).

You can make a referral by telephone, email or post:

* Call 0300 300 1485
* Email referral.lypft@nhs.net \*
* Address: Referral Administration Office, Leeds and York Partnership NHS Foundation Trust, The Becklin Centre, Alma Street, Leeds, LS9 7BE

\* Please note the SPA Team email inbox is not continually monitored. For referrals that require an immediate response please call 0300 300 1485. The SPA Team does not accept referrals by fax.

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