

**COMMUNITY LEARNING DISABILITY TEAM**

**REFERRAL FORM**

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| Please complete all sections to ensure your referral is correctly allocated. Where there is not enough information provided, we may need to return the form to the referrer for more information.Please provide enough information to help us understand why involvement of Specialist Learning Disability Services is needed.Please attach letters, documents and reports where these can help us make decisions about the person’s eligibility for Learning Disability Services and meeting their health needs.Where appropriate place an “x” in the relevant box on the form. |

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| **What is a Learning Disability?**To have a learning disability the person must have all three of the issues indicated below:* Have an Intelligence Quotient (IQ) of below 70. They will have had great difficulties with schoolwork and probably have attended special school / SILC.
* 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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| **Who do the Community Learning Disability Team Work With?**Our specialist Community Learning Disability Teams will accept referrals for a person with the presence of a learning disability who also has 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, exclusion, or significantly impact on the person’s quality of life.
* The service user requires an integrated specialist Learning Disability Team approach to care. Learning Disability Health professionals from different disciplines need to be involved at the same time.
* The service user’s learning disability is impacting on their ability to engage/comply with health need interventions.
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The completed referral form should be sent to the Single Point of Access (SPA) Team:

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| By post to:Referral Administration OfficeLeeds and York PFTSingle Point of AccessThe Becklin CentreAlma StreetLeeds LS9 7BE | By email to: referral.lypft@nhs.netFor referrals that require an immediate response, or if you need assistance completing this form, please call the Single Point of Access Team on: **0300 300 1485** |

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| **Service User Details** |
| **Title:** | **Forename/s:** | **Surname (alias/previous name):** |
| **Address:** |  | **Postcode:** |
| **NHS Number:** |  | **Date of Birth:** |
| **Telephone Number:** |  | **Sex:** | Male |  | Female |  |
| **Type of accommodation:** | Lives alone |  | Lives with family |  | Lives with partner /spouse |  | Lives with other |  |
|  | No fixed abode |  | Residential care |  | Lives with parent/ guardian |  | Supported living |  |
| **Smoking status:** | Smoker |  | Never smoked |  | Ex-smoker |  |  |
| **Employment status:** | Employed |  | Retired |  | Self-employed |  |  |
|  | Student |  | Unemployed – seeking work |  | Unemployed – long term sick |  |  |
|  | Unpaid /voluntary |  | Unemployed- not seeking work |  | Aged 70+ not applicable |  |  |
| **Language:** spoken by service user and principal carer(s): | Is an interpreter required? | Yes | No |
| **Marital status:** | Single |  | Married / civil partner |  | Separated |  |  |
|  | Divorced |  | Surviving partner /widowed |  | Client not disclosed |  |  |
| **Ethnicity:** |  | **Religion:** |  |

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| **Service User’s GP Details** |
| **Name:** |  | **Telephone number:** |
| **Surgery Address:** |  | **Postcode:** |

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| **Main Carer Details (eg family, keyworker)** |
| **Name:** |  | **Telephone number:** |
| **Address:** |  | **Relationship to service user:** |
| **Can the carer be contacted about this referral?** | Yes |  | No |  |  |

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| **Referrer Details** |
| **Name:** |  | **Relationship to service user:** |
| **Address:** |  | **Telephone number:** |
| **Email address:** |
| **Referrer type:** | LTHT |  | LYPFT staff |  | Police |  | LCH |  | GP |  | CAMHS |  |
|  | Hospice |  | Housing |  | ASC LD |  | Day Service |  | SSL |  | Transitions |  |
|  | Respite |  | Social Services |  | Care Management |  | Self |  | Relative / carer |  | Other (specify) |
| **Care Manager Details** |
| **Name:** |  | **Telephone Number:** |
| **Address:** |  | **Email address:** |

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| **Reason for Referral****Please give as much detail as possible below, or attach a letter (attach additional pages if needed)** **Please ensure that the points on Page 1 of this form have been addressed to enable us to make a decision about the person’s eligibility for the Community Learning Disability Team.****Please provide information about how often any Challenging Behaviour occurs, and how severe it is.****Please provide information about specific incidents and events if there are concerns about a person’s safety.** |
| **Has the service user been informed and agreed to the referral?** | **Yes** |  | **No** |  |
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| **Risk (please provide information on the following areas of known risks)** | **Yes** | **No** |
| Is the person vulnerable to risk (self-neglect, physical health, physical, sexual or financial abuse)?**If yes, please give details:** |  |  |
| Does the person pose a known risk to themselves (suicidal ideation, substance misuse, self-harm)? **If yes, please give details:** |  |  |
| Does the person pose a known risk to other people (property damage, physical harm, sexual harm)? **If yes, please give details:** |  |  |
| Does the person pose a known risk to staff and professionals? Is a joint visit necessary? **If yes, please give details:** |  |  |
| 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? **If yes, please give details:** |  |  |
| Are there any known Safeguarding issues that you are aware of? **If yes, please give details:** |  |  |
| **Mobility Issues** |
| Does the person have a physical disability? Do they have any access problems in attending appointments? **If yes, please give details:** |  |  |
| **Sensory Issues** |
| Does the person have any sensory issues? **If yes, please give details:** |  |  |
| **Communication Needs** |
| Does the person have any information or communication needs, eg need information in braille, easy read, large print or via email? **If yes, please give details:** |  |  |
| **Signature (please sign and date this referral)** |
| Signed: | Dated: |