**Learning Disability Services Referral Form**

*Prior to completing this referral, please ensure you have read and followed the guidance sheet on how to complete this form and whether the individual meets the criteria for this service.*

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT’S INFORMATION** | | | | | | | | **Referral Date:** | |  | | |
|  | | | | | | | | | | | | |
| **Name:** |  | | | | | | | **D.O.B.** | |  | | |
| **Address:** |  | | | | | | | **Tel. No’s.:** | |  | | |
| **NHS No:** | |  | | |
| **Gender:** | |  | | |
| **Ethnicity:** | |  | | |
| **Language used** *(do they require an interpreter?)* | |  | | |
| **Current/previous Diagnoses:** | |  | | |
| **Is client aware of the referral?** | | | | | | **Yes** | |  | **No** | | |  |
| **Does the client consent to the referral?** | | | | | | **Yes** | |  | **No –** *they do not consent* | | |  |
| **No –** *they lack capacity and this referral is being made under best interest’s under the Mental Capacity Act (2005)* | | |  |
| **Who should we contact about this referral?** *(Please provide name, relationship to client and contact details)* | | | | | | | |  | | | | |
| **Next of Kin details**  **(do not leave blank)** | | | | **Name:** | | | |  | | | | |
| **Address:** | | | |  | | | | |
| **Telephone no.:** | | | |  | | | | |
| **GP Practice** | | | | | **Name:** | | |  | | | | |
| **Address:** | | |  | | | | |
| **Telephone no.:** | | |  | | | | |
| **REFERRER’S INFORMATION** | | | | | | | | | | | | |
| **Name:** | | |  | | | | **Relationship to client:** | | | |  | |
| **Address:** | | |  | | | | **Telephone no.:** | | | |  | |
| **Email address:** | | |  | | | | | | | | | |
| **WHAT’S THE REFERRAL FOR?** | | | | | | | | | | | | |
| **What does the client need help with?** |  | | | | | | | | | | | |
| **Is there anything you think might help?** |  | | | | | | | | | | | |
| **Has the person had help with this before? What has worked in the past?** |  | | | | | | | | | | | |
| **What does the person have in place that currently keeps them safe and well?** |  | | | | | | | | | | | |
| **Risk** (do you feel there are any risks associated with this person?) | Would the client pose a risk to self?  yes(describe below)  no not known  Would the client pose a risk to others? yes(describe below)  no not known  **Please identify if there are any other risks to be considered/ precautions if making a home visit:** | | | | | | | | | | | |
| **OTHER PEOPLE AND SERVICES INVOLVED**  *We need to know the names of other people/services that are involved in the care of the client, including relevant family members, professionals and carers. Please identify if the criminal justice system, MAPPA or the Forensics Outreach Liaison Service are involved.* | | | | | | | | | | | | |
| **Role/Relationship to client** | | **Name** | | | | | | | | **Telephone Number/ Email** | | |
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| **Once you have completed this form, please email to:** [**hnf-tr.adultldreferrals@nhs.net**](mailto:hnf-tr.adultldreferrals@nhs.net)  To avoid delay, please ensure that the form is fully completed; otherwise it will be returned to you. | | | | | | | | | | | | |