

## Specialist Adult Referral Community Learning Disabilities Team

## Ref No. R1

**THIS FORM MUST BE COMPLETED IN FULL TO ENABLE THIS REFERRAL TO BE PROCESSED**

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| **Name of Person Being Referred** | | |
| **NHS Number** | **Title** | **Sex Female/Male** |
| **Ethnicity** | | |
| **Address**    **Postcode** | **Tel No** | **Mobile** |
| **Marital Status** | **Religion** |
| **DoB** | **Occupation** |
| **Next of Kin**  **Address/**  **Telephone** |  | |
| **Who does the person live with and who is responsible for their care?** | **Significant others**  **and contacts** |  |
| **Does the person have an independent advocate?** | ***❑ Yes ❑ No*** | |
|  | ***If yes, please provide contact name and details*** | |
| ***Has the person being referred been diagnosed with a learning disability? ❑ Yes ❑ No***  ***Where possible please attach documentation/evidence about the person’s diagnosis***  ***If No, why do you feel the person may have a Learning Disability?*** | | |
| **G.P** | **Telephone No.** | |
| **Referrers Details** | **Relationship to Client** | |
| **Address**  **Postcode** | **Tel No** | |
| **Email Address** | **Signature** | **Date** |
| ***Is the person aware of this referral? YES / NO***  ***Does this person have the capacity to consent to referral? YES / NO***  ***Are there issues relating to capacity in regards to this referral? YES /NO***  **Is the person able to attend a clinic appointment? YES / NO**  **What is the best way to contact the person?**  ❑ Standard letter ❑ Text ❑ Easy Read letter ❑ E-mail ❑ Telephone contact ❑ Through a carer  **Is an interpreter required? YES / NO If YES, preferred language?**  **Is a British Sign Language Interpreter required? YES / NO** | | |
| **Safeguarding: - *Are there any known safeguarding concerns at the time of referral (i.e. regarding a child, person being referred?) YES / NO***  ***Please give details that can be shared of any of the above:*** | | |
| **Reason for Referral:** | | |
| **Please return this fully completed referral form – it is the responsibility of the referrer to complete this form in full to progress the request. Please note we cannot process the referral without this information**  **Email to:** [**CDNLD.Admin@nhs.net**](mailto:CDNLD.Admin@nhs.net)  **Post to: Adult Community Learning Disability Team East**  **Mytton Oak Unit**  **Royal Shrewsbury Hospital**  **Shrewsbury**  **SY3 8XQ**  **If you have any queries please contact the team on: 01743 211210** | | |
| **FOR OFFICE USE ONLY:**  **Previously open to team Yes/No**  **Any relevant additional information:** | | |