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| **Personal Details** |
| **Name** | **DOB** | **NHS No**.  | **NOK Name:** |
|  |  |  |  |
| **Address** | **Tel No:** | **Email:** | **Relationship:**  |
|  |  |  |  |
| **Contact Details:** |
|  |
| **Ethnicity** |  | **Referral Date** |  |

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| **Professionals Details** |
| **Referrer Name & Role:** | **GP name:** |
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| **Referrer contact details:** | **GP Contact Details:**  |
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| **Other professionals involved, including professionals from the LD health team and social care (include contact details)** |
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| **Background** |
| **Does this person have a learning disability? (Contact us if you need an information sheet ‘What is and What isn’t a Learning Disability’). Please give details of any previous assessments and specific difficulties.**  |
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| **Other diagnosis in addition to LD? (E.g. mental health, dementia, epilepsy etc.)** |
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| **What school did this person attend?**  |
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| **Reason for referral. Please tick and give reasons below:** |
| **Behaviour change** |  | **Professional Consultation for carer** |  |
| **Mental health**  |  | **Psychological Support**  |  |
| **Access to mainstream health services** |  | **Physical health**  |  |
| **Specialist Assessment/diagnosis** |  | **Transition or out of area** |  |
| **Details:** |
| **What does the person want us to support them with? (What outcome are they hoping for?)** |
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| **Can this person access mainstream health and wellbeing services (e.g. Weightwatchers, exercise classes, LIFT Psychology, Health Ambassadors etc.) with reasonable adjustments? If not, please say why no**t.  |
|  |
| **Who supports this person day to day (give details, including type of care and amount of hours)?**  |
|  |
| **Does this person have needs regarding social care, housing, and criminal justice system or managing finances? (Please give details).** |
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| **What long term support will be available to carry on any interventions/treatments advised by the LD health team? (To prevent recurrence of the same problem).** |
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| **Is there anything we should know before contacting this person? (E.g. communication issues, support needs, religion etc.)** |
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| **Consent** |
| **Has the person consented to this referral?**  |
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| **If the person lacks capacity to consent, please give details of the Mental Capacity Assessment and Best Interests decision relating to this referral.**  |
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| **Risk**  |
| **How urgently do you believe intervention from the LD team is needed and why?**  |
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| **Is this person safe? If not, why not?**  |
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| **Are other people at risk as a result of this person’s actions? Please describe.** |
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| **Do you anticipate a crisis in the near future? (if so, please describe)** |
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| **How will the client be supported if this referral is not accepted by the LD Health Team?**  |
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| **Are there any risks relating to lone working? Please describe.** |
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| **Supporting Documents** |
| **Please attach the following documents where available. This will help us to triage and allocate this referral if accepted.**  |
| **Latest Social Care Assessment** | **Required** |
| **Current risk assessment** | **Required** |
| **Crisis/contingency plan** | **Required** |
| **Care plan**  | **Required**  |
| **Previous cognitive/other assessments** | **Preferred** |
| **Reports/documents that will help us to understand the person and their needs.**  | **Preferred** |
| **If the person lacks capacity to consent, please give details of the Mental Capacity Assessment and Best Interests decision relating to this referral.**  |
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| **Return Address** |
| Please return this form to:Avon & Wiltshire Mental Health Partnership NHS TrustLearning Disability Health TeamChatsworth House6 Bath RoadSWINDONSN1 4BP  |

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| **For official use only** |
| Date referral received: |
| Date | Referral action:  |
|  | Triaged (who by and date)Date discussed at MDT Returned to referrer (incomplete)Inappropriate referral:MDT recommendations:Allocated (who to)Waiting list for allocationSignposted Date closed |