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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Referral for Learning Disability Team*** | | | | | | | | | | | | | |
| **Family name:** | |  | | | **Given name:** | |  | | **Preferred Name:** | | | |  |
| **Title:** | |  | | | **Date of Birth:** | |  | | **Marital Status:** | | | |  |
| **Gender:** | |  | | | **Preferred Language:** | | |  | | | | | |
| **NHS No:** | | | |  | | | | | | | | | |
| **Address and Postcode (please enter current address if different from home address)** | | | |  | | | **Mobile number** | | |  | | | |
| **GP Practice & contact number** | | |  | | | |
| **Phone number** | | |  | | | | **Ethnicity** | | | | |  | |
| **Employment status** | | |  | | | | **Religion** | | | | |  | |
| **Do you consent to text messages for communication – Yes or No**  **If yes, please provide preferred number** | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | |
| **Carer to contact** | | |  | | | | | | | | | | |
| **Relationship** | | |  | | | | | | | | | | |
| **Tel no** | | |  | | | | | | | | | | |
| **Address** | | |  | | | | | | | | | | |
| ***Referral details* (if self referral address will be assumed to be as above. If in hospital identify person’s ward)** | | | | | | | | | | | | | |
| **Referral date** | | |  | | | **Referrer name & designation** | | | | | |  | |
| **Contact telephone number** | | |  | | | **Email address** | | | | | |  | |
| **Expected date of discharge**  **(inpatient only)** | | | | | | |  | | | | | | |
| **Does the person have a learning disability or identify as having a learning disability?** | | | | | | |  | | | | | | |
| **Has the person agreed to the referral? (Consider capacity to consent to being referred. Capacity needs to be decision specific) - Yes/No If not, why not?**  **Does the invididual being referred agree that this referral may be shared as needed to support their care:**  **Details of information that cannot be shared with any particular service or person?**  **If the CLDT do not know the person, we will contact them or named carer above to gather more information.**  **Reason for referral:**  ***(What is the current issue? How long has this been happening? Any recent life event such as bereavement/illness/change in care/breakdown in relationships? If behavioural, any triggers?***  ***What helps when a person is distressed? What has been done so far to help the current presentation?)***  ***What support do you hope to gain from the CLDT?*** | | | | | | | | | | | | | |
| **Risks** ***(including risk of harm or neglect to self/harm to others or abuse from others/placement breakdown/safeguarding)*** | | | | | | | | | | | | | |
| ***(access details – key safe, hard of hearing)*** | | | | | | | | | | | | | |
| **Patient signature** |  | | | | | | **Date** | | | |  | | |
| **Referrer signature** |  | | | | | | **Date** | | | |  | | |
| **Print name of referrer** |  | | | | | | **Designation of referrer** | | | |  | | |

**Please return the referral via the following secure email address**

[**Livewell.cldtreferrals@nhs.net**](mailto:Livewell.cldtreferrals@nhs.net)

**Or by post to**

**Community Learning Disabilities Team, Westbourne, Scott Business Park, Beacon Park Road,**

**Plymouth, PL2 2PQ**