|  |
| --- |
| ***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**

**Or by post to**

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

**Plymouth, PL2 2PQ**