\****Please complete all sections or referral will be declined.***

**\*Person being Referred:**

|  |  |
| --- | --- |
| Name: | DOB: |
| Address: | NHS No: (if known): |
| Tel. No: | Care First No. (if known): |

**\*Key contact person for further information if required:**

|  |  |
| --- | --- |
| Name: | Tel. No: |
| Email: |
| Relationship to client: | Address: |

**\*Referrer Details:**

|  |  |
| --- | --- |
| Date of referral: | |
| Referred by: | Role: |
| Address: | Tel. No: |
| Email: |

**\*Does the person being referred have an established Learning Disability?**

|  |
| --- |
| Yes: *Please provide details* |
| No: *What are your reasons for believing that this person may have an LD i.e: special school, poor social functioning etc:* |

**\*Is the person aware of or given consent to this referral?** *(consider consent/capacity)*

|  |
| --- |
| Yes/No If not why not?: |

**\*Reason for referral and brief history of presenting problem:**

|  |
| --- |
|  |

**\*What has been done so far to try and help with the above:**

|  |
| --- |
|  |

**\*Known Risks/Priority factors:** *(if yes to any of these please give details)*

|  |
| --- |
| **Risks:** |
| Is there a risk of neglect, abuse or Vulnerable Adult issues?  Are there any children in the household? *If Yes, please provide Name(s) & DOB(s)*  Are there any child protection issues?  Is there a risk of self-harm?  Any significant changes/events in the person’s health status e.g. choking, weight loss, rapid loss of physical skills?  Is the person experiencing/thought to be experiencing side effects from prescribed medication?  Is the person’s current or residential placement at risk of breaking down?  Are there significant changes to the person’s behaviour?  Does the person have inadequate support networks?  Are there any transition issues?  Are there any safeguarding concerns?  **Details:** |

***Continued* \*Known Risks/Priority factors:** *(if yes to any of these please give details)*

|  |
| --- |
| **Risk to others:** |
| Any history of physical aggression?  Any history of verbal aggression?  Any sexually inappropriate behaviour?  Any environmental risks e.g. access, poorly lit entrance, animals etc.?  **Details:** |
| **Other useful info:** *(e.g. access details – key safe, hard of hearing etc)* |
|  |

**\*Contact details/names/relationship of those involved:** *(e.g. key workers, other supports, significant people in the person’s life)*

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| --- |
|  |

**\*What is the best way to contact the person?** *(please specify)*

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|  |

**\*Where is the best place to see the person?**

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| --- |
|  |

**Any other information you feel is relevant to share:**

|  |
| --- |
|  |

**Please return to:** Referral Co-ordinator, CLDT, Westbourne, Scott Business Park, Beacon Park Road, Plymouth PL2 2PQ

**Livewell.cldtreferrals@nhs.net**