\****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?**

|  |
| --- |
|  |

**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**