NHS Haringey Clinical Commissioning Group

Haringey LONDON

LEARNING DISABILITIES PARTNERSHIP

REFERRAL FORM

What you tell us will help us decide how we may be able to help.

Date of Referral…….. **Mosaic No** (office use)**: ……..**

1. TITLE	**Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐	**Male** ☐ **Female** ☐
NAME	**First Name:**	**Family Name:**
Date of Birth: **Day** **Month** **Year**		
ADDRESS:		**Telephone No:**
		Mobile Number:
Postcode:		**NHS Number:**

2. What is the best way to contact this person?

☐ Telephone person directly ☐ Telephone carer (please give details)

☐ Text person/ carer directly ☐ Email (please give details):

First language: Is an interpreter required? Yes ☐ No ☐

3. Type of Accommodation			
❑ Residential Care ❑ Hospital	❑ Nursing Home ❑ Living with family	❑ Living Alone ❑ Supported Living ❑ Live with carer/foster carer	❑ Adult Family Placement ❑ Privately rented/owned

4. How long has the person lived in Haringey?	
5. Next of kin/ Significant other	**GP:**
Relationship to client: **Address:**	**Address:**
Tel. No: **Mob. No:**	**Tel. No:**

6. Does the person have parental responsibilities for any children?

Yes ☐ (Please provide details)

No ☐

If yes, please provide details including name(s), date of birth(s) and place of residence)

7. Does the person receive service from Haringey Learning Disabilities Partnership?

Yes ☐ (Please only answer questions 11 & 20)

No ☐

8. Has the person received a Learning Disability service from any other team previously?

Yes ☐ (Please provide details)

No ☐

If yes, please provide details (other local authority or similar service in another country)

9. Is the person a British National or UK Citizen?

Yes ☐

No ☐ (Please provide details of immigration status)

This does not mean we will not assess you but could affect the services that you are entitled to.

10. Has the person consented to this referral?

Yes ☐

No ☐ (Please provide details of why)*

**By law, the Mental Capacity Act (2005) says we have to make sure our service users consent to this referral. If a person lacks the capacity to consent, a best interest decision must be made on the person's behalf. Please follow the Mental Capacity Act guidance.*

11. Reason for referral
(Please provide clear information about why this referral is being made, e.g. concerns about behaviour, contact with Mental Health services, risks or support needs etc. Please be as specific as possible, and give examples and reasons why the support is required).

12. Physical health information, including diagnosis and medication (including any relevant past medical history e.g. head injury, current health professionals involved.)

13. The following questions will help us to decide if the person meets eligibility criteria for our service. Please answer all the following questions or your referral may be returned.

1. Is there a diagnosis of a Learning Disability (mental handicap, global developmental delay, intellectual disability, mental retardation, etc.) in any notes?

Yes ☐ (Please provide details)

No ☐

If yes, please provide details (e.g. Down's Syndrome, Retts Syndrome diagnosed by GP, consultant and date of IQ assessed as below 70. Please provide reports)

Did this start before the age of 18? **Yes ☐ No ☐**

2. Has the person had a brain injury which has caused cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their

everyday life)?

Yes ☐ (Please provide details)

No ☐

If yes, please provide details (age brain injury occurred?)

3. Did the person attend any special schools or have additional support in mainstream school? If so did they have a Statement of Special Educational Needs (SEN)?

Yes ☐ (Please provide details)

No ☐

If yes, please provide details and send a copy of any SEN statement if available.

4. Did the person take any exams?

Yes ☐ (Please provide details)

No ☐

If yes, please provide details (what is the level of qualification, grade and subject)

5. Has the person ever had employment? (Paid or voluntary)

Yes ☐ (Please provide details)

No ☐

If yes, please provide details (Job role, reason for leaving, did they have additional support to carry out the job)

6. Is the person in receipt of any benefits?

Yes ☐ (Please provide details)

No ☐

If yes, please provide details and rates (e.g. DLA, ESA, JSA)

14. Does the person have difficulty in completing activities of daily living:
If yes, please give examples of the support needed

Communication (e.g. non-verbal, uses sign language/ Makaton, uses photographs/ symbols. **Please give examples:**
Reading / Writing (e.g. can only read simple sentences? Can write a shopping list?) **Please give examples:**
Independent Living Skills (e.g. preparing a meal, cleaning, paying bills, shopping, budgeting, staying safe, dealing with emergencies) **Please give examples:**
Personal Care (e.g. washing face, bathing, cleaning teeth, using toilet, dressing, Is this difficulty due to physical disability?) **Please give examples:**
Behaviours that Challenge (e.g. aggression, disinhibition, inappropriate behaviour, e.g. removing clothing in public?) **Please give examples:**
Travelling Independently (e.g. can use maps, timetables, can travel on unfamiliar routes, can manage unexpected diversions?) **Please give examples:**

15. Any risks/ safeguarding concerns? **If yes, please provide details**
1. Is the person at risk of harm, e.g. self harm, harm from others?

Yes ☐ **(Please provide details)**

No ☐

If yes, please provide details:

2. Are there any risks around meeting with this person, e.g. risk of harm to others?

Yes ☐ **(Please provide details)**

No ☐

If yes, please provide details:

3. Do you have a risk assessment relating to the person being referred?

Yes ☐ **(Please provide details)**

No ☐

If yes, please enclose assessment

☐ I have attached risk assessment to this form

4. Please provide details of any former or current safeguarding concerns.

5. Does the person have any history or current involvement with the Criminal Justice System/any convictions?

Yes ☐ **(Please provide details)**

No ☐

If yes, please provide details:

16. Other people involved with this person and their contact number

	Name	Department	Role	Contact No.
Mental Health Services				
Children's Services				
Social Services				
Housing				
Specialist Consultant				
District Nurses				
Health Services				
Other				

17. Is there anything more you would like to tell us?

18. What is the person's ethnic origin? (not place of birth)

White

British [ ]
Irish [ ]
Greek Cypriot [ ]
Turkish Cypriot [ ]
Kurdish [ ]
Turkish [ ]
Any Other White, (please write in)
……

Mixed

Mixed White and Black Caribbean [ ]
Mixed White and Black African [ ]
Mixed White and Asian [ ]
Any other mixed background [ ]
(please write in)
……

Asian or Asian British

Indian [ ]
Pakistani [ ]
Bangladeshi [ ]
East African Asian [ ]
Any Other Asian Background, (please write in) [ ]
……..

Black or Black British

Caribbean [ ]
African [ ]
Any Other Black Background, (please write in)
……

Chinese or Other Ethnic Group

Chinese [ ]
Other [ ]

19. Religion Practising Yes ☐ No ☐

"Please take care to complete this referral form in full as incomplete or insufficient information may delay our ability to process this referral".

20. If you are completing this form on behalf of the person please write YOUR details below

NAME:

ADDRESS:

TELEPHONE NUMBER: MOBILE NUMBER:

Email:

Best days/time for contact:

What is your relationship to this person?

PLEASE RETURN THIS FORM WITH ACCOMPANYING WRITTEN EVIDENCE (e.g. STATEMENT OF SPECIAL EDUCATIONAL NEEDS/ PSYCHOLOGY, PSYCHIATRIC ASSESSMENTS REPORTS OR ANY OTHER DOCUMENTS) TO:

Haringey Learning Disabilities Partnership
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