Person's Name: DOB:

Office Use only:
Date received:

Learning Disabilities Health Team Referral Form

Berkshire Healthcare NHS Foundation Trust

Referral Forms to be sent to the relevant Community Team for People with Learning Disabilities (CTPLD)

Date of Referral:		
Details of person being referred:		
Title:	**Forename:** (include preferred names if relevant)	**Surname:**
Date of Birth:		**NHS ID and/or RIO ID and/or Social Care ID:**
Main Address:		**Temporary address / respite address:**
Your phone number:		**Contact person and number** (if different to referred person):
Email:		**Communication Preferences:** **Face to Face appointments**: British Sign Language ☐ Lip Reading ☐ Advocate/Carer required ☐ Makaton sign ☐ **Making Contact:** Email ☐ Text ☐ Phone ☐ Other ☐ **Written:** Large font ☐ Email ☐ Easy Read ☐ Braille ☐ Audio tape ☐ Pictures/photo/ symbols ☐ **Duplicate Information to:** Formal Carer ☐ Parent/Guardian ☐ Other ☐
Name of main carer / next of kin (please state): **Relationship to person being referred:**		
Address: **Telephone number:**		
GP name & surgery:		
GP phone number		
Does this person have learning disabilities?		
Main diagnosis and other health conditions (and any other impairments):		
Current medication:		
Any known allergies or sensitivities:		
Does this person have epilepsy?	Yes ☐	No ☐
What is the person's: Weight…….. Height…… NB This information must be completed if the referral is for the Dietitian, Nurses or Speech and Language Therapist (eating & drinking assessments)		
Does this person smoke?	Yes ☐ If yes would they like to be referred to the Smoking Cessation Service Yes ☐ No ☐	No ☐

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Consent:	
Is the referred person aware of this referral? Yes ☐ No ☐ **Has the referred person consented to this referral?** Yes ☐ No ☐	**If no – please state why*? If person lacks capacity, has a Best Interest decision been made – provide details***
Care manager/local authority holding responsibility:	**Telephone number:**

Reason For Referral

Please give a summary of the reason why you / the person being referred needs support from a Health and Social Care service in CTPLD. Please be specific and attach any relevant information to help with the referral.

Who do you think the referral is for?

☐ Challenging Behaviour Specialist ☐ Dietitian ☐ Health Support Worker ☐ Nursing
☐ Occupational Therapy ☐ Physiotherapy ☐ Psychiatry ☐ Psychology
☐ Speech and Language Therapy ☐ Social Care Referral (East Berkshire only)

What are the person's desired outcomes for this referral?

What supporting documents / reports are attached? (e.g. psychological assessment; health information; educational information etc.)

Risk Factors: Please tick

	Past	Present	Not Known		Past	Present	Not Known
Deliberate Self-Harm	☐	☐	☐	**Forensic History**	☐	☐	☐
Suicide	☐	☐	☐	**Substance Misuse**	☐	☐	☐
Self-Neglect	☐	☐	☐	**Housing Problems**	☐	☐	☐
Abuse from Others	☐	☐	☐	**Non-Compliance with Treatment**	☐	☐	☐
Violence to Others (verbal) (including professionals)	☐	☐	☐	**Has served in the armed forces?**	☐	☐	☐

Referrer's Details:	
Name of referrer:	**Professional role / support to the person:**
Contact details: **Address:**	**Signature of referrer:**
Telephone Number:	**Email:**

Other Services Involved:

Other Professionals involved and their roles in supporting the service user (please include contact details)

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Living environment (current accommodation):

Own Home ☐ Family/Carers Home ☐ Residential ☐ Supported Living ☐ Other (Please state)……..…

Settled Accommodation Indictor:
Is permanent residence settled or non-settled? Settled ☐ Non-settled ☐

Employment status:

Employed ☐ Unemployed ☐ Voluntary Work ☐ Supported Work ☐ Student ☐ Not Applicable ☐ Not Known ☐

Weekly hours worked? ☐

Demographic Details:

Ethnicity ***(please tick)***

Asian Bangladesh	☐	Ethnic Other	☐
Asian Indian	☐	Mixed White & Asian	☐
Asian Other	☐	Mixed White & Black African	☐
Asian Pakistani	☐	Mixed White & Caribbean	☐
Black African	☐	Mixed Other	☐
Black Caribbean	☐	White Other	☐
Black Other	☐	White Irish	☐
Chinese	☐	White British	☐
Declined to answer	☐		

Marital Status ***(please tick)***

Civil Partnership	☐	Divorced / Person who's Civil Partnership is dissolved	☐
Married	☐	Not Disclosed	☐
Separated	☐	Single	☐
Widowed/Surviving Civil Partner	☐		

Religion: ***(please tick)***

Atheist	☐	Judaism	☐
Buddhism	☐	Islam	☐
Christianity	☐	Sikhism	☐
Hinduism	☐	Any Other belief	☐
Prefer not to say	☐		

Does this person have a chronic illness or disability? Yes ☐ No ☐ Prefer not to say ☐

Along term medical condition ☐ Mobility problems ☐ Sight loss ☐ Hearing loss ☐

A Learning Disability ☐ Mental ill health ☐ Other (Please state)……

Which of the following best describes – gender?

i) Male ☐ ii) Female ☐

iii) Prefer to self-describe ☐ iv) Prefer not to say ☐

Which of the following best describes – sexual orientation?

i) Straight / heterosexual ☐ ii) Lesbian/ Gay ☐ iii) Bisexual ☐

iv) Prefer to self-describe ☐ v) Prefer not to say ☐

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Please use for any additional information you feel would be helpful

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