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:**
Name of main carer / next of kin (please state): **Relationship to person being referred:**		**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 ☐
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 ☐

Person's Name: DOB:

Office Use only:
Date received:

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)

Person's Name: DOB:

Office Use only:
Date received:

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 ○

Person's Name: DOB:

Office Use only:
Date received:

Please use for any additional information you feel would be helpful

Bracknell CTPLD 2nd Floor, North Time Square Market Street Bracknell RG12 1JD Tel: 01344 354 466 Duty.CTPLD@Bracknell-Forest.gov.uk	Slough CTPLD Observatory House 25 Windsor Road Slough SL1 2EL Tel: 01753 475 111 CTPLD.Duty@slough.gov.uk	WAM CTPLD St Marks Hospital St Marks Road Maidenhead SL6 6DU Tel: 0118 904 2834 CTPLD@rbwm.gov.uk
Wokingham CTPLD 1st Floor, The Old Forge 45-47 Peach Street Wokingham RG40 1XJ Tel: 0118 936 8681 WokinghamCTPLD@berkshire.nhs.uk	Reading CTPLD Erlegh House Earley Gate Whiteknights Road Reading RG6 6BZ Tel: 0118 214 3298 ReadingCTPLD@berkshire.nhs.uk	Newbury CTPLD West Street House West Street Newbury RG14 1BZ Tel: 01635 503 551 NewburyCTPLD@berkshire.nhs.uk