

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 <input type="checkbox"/> Lip Reading <input type="checkbox"/> Advocate/Carer required <input type="checkbox"/> Makaton sign <input type="checkbox"/> Making Contact: Email <input type="checkbox"/> Text <input type="checkbox"/> Phone <input type="checkbox"/> Other <input type="checkbox"/> Written: Large font <input type="checkbox"/> Email <input type="checkbox"/> Easy Read <input type="checkbox"/> Braille <input type="checkbox"/> Audio tape <input type="checkbox"/> Pictures/photo/symbols <input type="checkbox"/> Duplicate Information to: Formal Carer <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other <input type="checkbox"/>	
Name of main carer / next of kin, and 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 <input type="checkbox"/> No <input type="checkbox"/>	
What is the person's: Weight..... Height..... 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 <input type="checkbox"/> No <input type="checkbox"/>	
		If yes would they like to be referred to the Smoking Cessation Service Yes <input type="checkbox"/> No <input type="checkbox"/>	

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Consent							
Is the referred person aware of this referral? Yes <input type="checkbox"/> No <input type="checkbox"/>				If no – please state why? <i>If person lacks capacity, has a Best Interest decision been made – provide details</i>			
Has the referred person consented to this referral? Yes <input type="checkbox"/> No <input type="checkbox"/>							
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? <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> Challenging Behaviour Specialist</div> <div style="width: 50%;"><input type="checkbox"/> Dietitian</div> <div style="width: 50%;"><input type="checkbox"/> Health Support Worker</div> <div style="width: 50%;"><input type="checkbox"/> Nursing</div> <div style="width: 50%;"><input type="checkbox"/> Occupational Therapy</div> <div style="width: 50%;"><input type="checkbox"/> Physiotherapy</div> <div style="width: 50%;"><input type="checkbox"/> Psychiatry</div> <div style="width: 50%;"><input type="checkbox"/> Psychology</div> <div style="width: 50%;"><input type="checkbox"/> Speech and Language Therapy</div> <div style="width: 50%;"><input type="checkbox"/> Social Care Referral (East Berkshire only)</div> </div>							
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Forensic History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Housing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse from Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Non-Compliance with Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Violence to Others (verbal) (including professionals)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has served in the armed forces?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referrer's Details:							
Name of referrer:				Professional role / support to the person:			
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 Indicator:

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	<input type="checkbox"/>	Ethnic Other	<input type="checkbox"/>
Asian Indian	<input type="checkbox"/>	Mixed White & Asian	<input type="checkbox"/>
Asian Other	<input type="checkbox"/>	Mixed White & Black African	<input type="checkbox"/>
Asian Pakistani	<input type="checkbox"/>	Mixed White & Caribbean	<input type="checkbox"/>
Black African	<input type="checkbox"/>	Mixed Other	<input type="checkbox"/>
Black Caribbean	<input type="checkbox"/>	White Other	<input type="checkbox"/>
Black Other	<input type="checkbox"/>	White Irish	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	White British	<input type="checkbox"/>
Declined to answer	<input type="checkbox"/>		

Marital Status (please tick)

Civil Partnership	<input type="checkbox"/>	Divorced / Person who's Civil Partnership is dissolved	<input type="checkbox"/>
Married	<input type="checkbox"/>	Not Disclosed	<input type="checkbox"/>
Separated	<input type="checkbox"/>	Single	<input type="checkbox"/>
Widowed/Surviving Civil Partner	<input type="checkbox"/>		

Religion: (please tick)

Atheist	<input type="checkbox"/>	Judaism	<input type="checkbox"/>
Buddhism	<input type="checkbox"/>	Islam	<input type="checkbox"/>
Christianity	<input type="checkbox"/>	Sikhism	<input type="checkbox"/>
Hinduism	<input type="checkbox"/>	Any Other belief	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>		

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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