

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: <input type="text"/>	
Details of person being referred:	
Title:	Forename: (include preferred names if relevant) <input type="text"/>
Surname: <input type="text"/>	
Date of Birth:	NHS ID and/or RIO ID and/or Social Care ID:
Main Address:	Temporary address / respite address:
Telephone 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 (please state):	
Relationship to person being referred:	
Address:	
Telephone number:	
GP name & surgery:	
Tel No:	
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..... 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 <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"/>

Person's Name:

DOB:

Office Use only:
Date received:

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							
<i>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.</i>							
Who do you think the referral is for?							
<input type="checkbox"/> Challenging Behaviour Specialist	<input type="checkbox"/> Dietitian	<input type="checkbox"/> Health Support Worker	<input type="checkbox"/> Nursing	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physiotherapy	<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Psychology
<input type="checkbox"/> Speech and Language Therapy	<input type="checkbox"/> 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	<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:			
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 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) 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

<p>Bracknell CTPLD 1st Floor, South Time Square Market Street Bracknell RG12 1JD</p> <p>Tel: 01344 354466 Fax: 01344 353266</p>	<p>Slough CTPLD Observatory House 25 Windsor Road Slough SL1 2EL</p> <p>Tel: 01753 690860</p>	<p>WAM CTPLD St Marks Hospital St Marks Road Maidenhead SL6 6DU</p> <p>Tel: 01753 638677</p>
<p>Wokingham CTPLD 1st Floor, The Old Forge 45-47 Peach Street Wokingham RG40 1XJ</p> <p>Tel: 0118 9368681</p> <p>WokinghamCTPLD@berkshire.nhs.uk</p>	<p>Reading CTPLD 7-9 Cremyll Road Reading RG1 8NQ</p> <p>Tel: 0118 2077684</p> <p>ReadingCTPLD@berkshire.nhs.uk</p>	<p>Newbury CTPLD West Street House West Street Newbury RG14 1BZ</p> <p>Tel: 01635 503551 Fax: 01635 503560</p> <p>Bks-tr.newburyctpld@nhs.net</p>