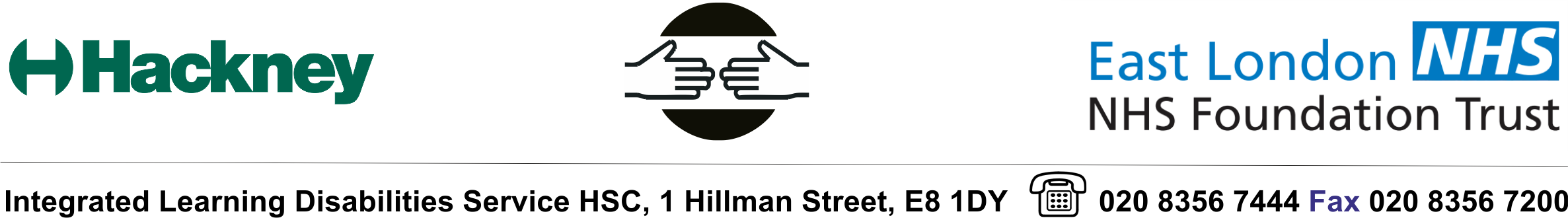
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**Hackney Integrated Learning Disability Service (ILDS)**

**REFERRAL FORM**

**In order to be eligible to receive services from the Hackney Integrated Learning Disability Service a person should meet all of the following criteria:**

* **Significant impairment of intellectual functioning.** A significantly reduced ability to understand new or complex information, in reasoning, abstract thinking and to learn and apply new skills. This can be seen as an inability to complete complex tasks which require planning, problem solving and considerations of safety and danger. A significant impairment may also be identified through formal cognitive assessment where an IQ score of <70 is obtained.
* **Significant impairment of adaptive and social functioning.** This indicates an individual’s ability to cope on a day-to-day basis in their own lives. This includes daily living skills in the areas of communication, self-care, home living (personal and domestic skills), social relationships, using community resources, travel, work, leisure, finances and budgeting and health and safety. Having a significant impairment in adaptive and social functioning suggests that the individual needs significant help in their day to day lives.
* **Age of onset before adulthood.** This means that the impairment was acquired before the age of 18 years.

In addition, the term ‘learning disabilities’ is not being used for people with specific areas of learning *difficulty* (e.g. dyslexia) who do not meet the criteria above or those whose difficulties may instead be due to mental health issues, substance misuse or who have had limited opportunities to learn.

**PLEASE COMPLETE THIS FORM AS FULLY AS POSSIBLE:**

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| **SECTION 1 -**  **This section is compulsory, if incomplete the referral will be returned to referrer for completion** | | | | | | | | | | | | | | | | |
| **ILDS reference number e.g. mosaic number (if known)** | | |  | | | | | | | | **NHS Number**  **(if known)** | | | |  | |
| **Referral Date:** | | |  | | | | | | | | | | | | | |
| **Name of person being referred:** |  | | | | | | | | | | **Date of Birth:** | | |  | | |
| **Gender:** | Male | | | | Female | | | | | | **Marital Status:** | | |  | | |
| Other: | | | | Prefer not to say | | | | | |  | | | | | |
| **Current Address:** |  | | | | | | | | | | | | | | | |
| **Postcode:** |  | | | | | | | **Contact Number:** | | | | Tel: | | | | |
| Mob: | | | | |
| **Email Address:** | | | |  | | | | | | | | | | | | |
| **GP Name:** | | | |  | | | | | | | | | | | | |
| **GP Address:** | | | |  | | | | | | | | | | | | |
| **GP Postcode:** | | | |  | | | | | | | **Contact Numbers:** | | Tel: | | | |
| **GP Email Address:** | | | |  | | | | | | | | | | | | |
| **Nationality:** | | | |  | | | | | | | **Employment Status:** | |  | | | |
| **Ethnicity:** | | | |  | | | | | | | **Religion :** | |  | | | |

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| **Has the person consented to this referral?** | | | | | | | | | | Yes | | | No |

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| **Communication & Interaction skills:** | | | | | | | | | | | | | |
| **Primary language:** | | |  | | | | | | | | | | |
| **Interpreter Required (Y/N):** | | |  | | | | | **Language required:** | |  | | | |
| **Communication methods used**  (e.g. speech, sign language such as Makaton, pictures, gesture, text) | | |  | | | | | | | | | | |
| **Communication skills**  (e.g. ability to initiate and sustain conversation, ability to get their message across, understanding meaning, hearing) | | |  | | | | | | | | | | |
| **Interaction skills** (e.g. listening and paying attention, eye contact, ability to take turns in conversation, difficulty interpreting social cues) | | |  | | | | | | | | | | |

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| **SECTION 2 -**  **Background information** | | | | | | |
|  | | | | **Tick**  **yes** | **Tick**  **No** | **Please specify details** |
| Is the person known to Hackney Integrated Learning Disability Service?  **If yes, go to Section 4. If not, please complete in full.** | | | |  |  |  |
| Has anyone ever told the person that they have a **learning disability?**  **If Yes**  Please attach any relevant assessments, reports and letters for background information | | | |  |  |  |
| Have they ever had a cognitive assessment?  (Please include report) | | | |  |  |  |
| Which school does/did the person attend?  Do/did they have an Educational Health Care Plan/EHCP (previously known as a ‘Statement of Educational Needs’) in school? | | | |  |  |  |
| Has the person ever been in paid employment or voluntary work? | | | |  |  |  |
| Can the person read and write? | | | |  |  |  |

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| **SECTION 3 -**  **Activities of Daily Living** | | | | | | | |
| **How does the person manage the following activities:** | | | | **Please tick one:** | | | **\* If not independent, describe what support and why it is needed.** |
| **Independent** | **With support\*** | **Done by others\*** |
| Keeping myself clean  (e.g. washing myself; dressing; using the toilet) | | | |  |  |  |  |
| Making snacks & cooking meals | | | |  |  |  |  |
| Keeping my home clean and tidy | | | |  |  |  |  |
| Keeping myself safe at home (e.g. responding to fire/emergency, safe to be alone at home) | | | |  |  |  |  |
| Using money  (e.g. shopping, managing bills, budgeting) | | | |  |  |  |  |
| Accessing the community and keeping safe  (e.g. using public transport, road safety, stranger danger awareness) | | | |  |  |  |  |
| Making & keeping friends and relationships | | | |  |  |  |  |

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| **SECTION 4 -**  **Medication (if known)** | | |
| **Medication Name** | **Dose** | **Frequency** |
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| **Allergies:** | | |
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| **SECTION 5 -**  **Risks** | | | |
|  | **Tick Yes** | **Tick**  **No** | **Please specify** |
| Suicidal Risk: |  |  |  |
| Risk to self: |  |  |  |
| Risk to others: |  |  |  |
| Risk to environments: |  |  |  |
| Risk from others or environment: |  |  |  |
| Dysphagia (choking risk, chest infections): |  |  |  |
| Other: |  |  |  |

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| **SECTION 6 -**  **Reason for referral:** | | | | | |
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| **ILDS discipline to be considered:** | | | | |
| **Discipline** | **Tick as appropriate** | | **From the information provided in Reason for Referral; Outline which discipline you require to meet the need.** | |
| **Dietetics** |  | |  | |
| **Nursing** |  | |  | |
| **Occupational Therapy** |  | |  | |
| **Physiotherapy** |  | |  | |
| **Psychiatry** |  | |  | |
| **Psychology** |  | |  | |
| **Social Work** |  | |  | |
| **Speech & Language Therapy (SLT)** |  | |  | |

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| **SECTION 7 -**  **Referrer’s Details:** | |
| **Referrer’s Name:** |  |
| **Referring Team/ Organisation:** |  |
| **Relationship to or current involvement with the service user:** |  |
| **Referrer’s Contact Details:** | |
| **Address:** |  |
| **Telephone Contact:** |  |
| **Email Address:** |  |

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| **SECTION 8 -**  **Other professionals or agencies involved** | | | | | |
| **Name:** | **Role:** | **Organisation:** | | **Email and telephone number:** | |
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**HACKNEY INTEGRATED LEARNING DISABILITIES SERVICE (ILDS)**

Hackney Service Centre, 1 Hillman Street, London, E8 1DY

Duty number: 020 8356 7444

Fax: 020 8356 7200

Email: [learningdisabilitiesduty@hackney.gov.uk](mailto:learningdisabilitesduty@hackney.gov.uk)

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