##### REFERRAL TO

##### SERVICES FOR PEOPLE WHO HAVE A LEARNING DISABILITY (SPLD)

##### SPECIALIST COMMUNITY HEALTHCARE TEAM

**Send this referral via email to-** [**elt-tr.spldreferrals@nhs.net**](mailto:elt-tr.spldreferrals@nhs.net)

Or by post to: The Receptionist, The Clinical Resource Centre, Twinwoods Health Resource Centre, Milton Road, Clapham, Bedfordshire, MK41 6AT

**ELIGIBILITY CRITERIA TO ACCESS OUR SERVICE:**

* Be registered with a GP in Bedfordshire
* Be aged 18 years or over (Referrals for young people approaching 18 will be accepted from 17 ½ years)
* Have a learning disability
* Consent to this referral
* Agreed to have their information shared where appropriate

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| **DETAILS OF PERSON BEING REFERRED (Print clearly: Use CAPITALS to identify client. etc. Please complete all pages. Unclear or incomplete referrals will be returned)** | | | | | | |
| **Name:** | | | **DOB:** | | | |
| **NHS No:** | | | **Ethnicity:** | | | |
| **Address:**  **Postcode:** | | | **Interpreter Required:**  **Yes**  **No**  If yes please state language | | | |
| **Telephone No:**  **Mobile No:** | | | **Email:** | | | |
| Funding authority | | |  | | | |
| **DETAILS OF NEXT OF KIN:** | | | | | | |
| **Name:** | | | | **Relationship:** | | |
| **Address:** | | | | | | |
| **Telephone:** | **Mobile:** | | | | **Email address:** | |
| **Advocate/ LPA/Court Appointed Guardian contact details** | | | | | | |
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| **GP details:** | | | | | | |
| **GP Name:** | | | | | | |
| **Address:** | | | | | | |
| **Telephone:** | | | | **Email:** | | |
| **Is this person on the GP Learning Disability register? Yes**  **/ No**  **Do they receive an Annual Health Check? Yes**  **/ No** | | | | | | |

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| **Best way of making contact** | | | | | | | | | | | | |
| Email | | | Text | | | | Phone | | | Letter | | |
| **Is there a documented diagnosis of learning disability? (If unsure please complete screening tool towards the end of referral)** | | | | | | | | | | | | |
| Yes | No | Diagnosis: | | | | | | | | | | |
| Mild | | Moderate | | | Severe | | | | Profound | | | Not known |
| **Which school did the person attend? Do they have an Educational Health Care Plan (ECHP) in place?** | | | | | | | | | | | | |
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| **Does the person consent to the referral: You must ensure that you are making this referral with the consent of the client and/or carer** | | | | | | | | | | | | |
| 1. Does the above named person understand why they are being referred? Yes / No  2. Is the person able to remember the reason for the referral and repeat it back to you?  Yes  / No | | | | | | 3. Does the person agree to this referral being made?  Yes  / No  4. If the person is unable to discuss the referral or is unable to consent, have you had a Capacity and Best Interest Discussion. Yes  / No  Date of meeting: | | | | | | |
| Does the person consent to having their information shared back with their GP surgery? Yes  / No  **If yes then no further information governance documentation is required to cover the transfer of patient data from ELFT to GP surgeries.** | | | | | | | | | | | | |
| **Reason for referral-** | | | | | | | | | | | | |
| **What is the presenting problem/clinical need?** (for example Activities of daily living, communication, eating and drinking, eyes and ears, accessing GP/ annual health checks, medication review, mobility, behaviour, mental health) | | | | | | | | | | | | |
| **How long has this been an issue?** | | | | | | | | | | | | |
| **Medication/ Allergies** | | | | | | | | | | | | |
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| **Please provide details of current and/or past professionals involved. E.g. Community Mental Health, Wellbeing Hub, Social worker, Day Services** | | | | | | | | | | | | |
| **Name** | | | | **Role** | | | | **Telephone/Mobile** | | | **Email** | |
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| **Risk factors:** |
| Please provide details of any immediate risk? What are the risks for the person themselves? Are there risks for other people? Are there any risks for professionals from our team when we visit? Are there any other challenges or issues that we need to know about before we work with this person? |
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| **Are you aware of any safeguarding issues?** |
| Yes  No  Don’t know |
| **If yes, please provide details below** |
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| **Is there anything else you need to tell us about this referral?** |
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| **Details about you, the referrer (Please give all details)** | |
| Full name of referrer | Relationship to patient |
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| Address: | Telephone / Mobile: | Email address: |

**Each referral may be allocated to a health professional (or professionals) at the team’s weekly Referral Allocation Meeting based on needs and resources, not necessarily to the health professional suggested by you.**

**Please note that some information in this form will be entered on the computer in accordance with the Data Protection Act. Some information may be shared with service colleagues on a need to know basis only.**

**Learning Disability Screening Tool**

**Use of the LD Screening Tool to support identification Screening Tool**

* This can help as a checklist for GPs and other professionals to assist them in identifying learning disability
* This is not intended as a diagnostic tool so apply sound clinical judgement

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| **Questions to consider** | **Yes** | **No** |
| Has anyone ever told the person that they have a learning disability? |  |  |
| Is there a diagnosis of a learning disability/mental handicap in any notes? IQ  under 70 |  |  |
| Did person attend any special schools (SILC) or were they statemented in mainstream school? |  |  |
| Did the person achieve qualifications at school?(GCSE at low grades could  indicate LD but high grade GCSE, A Levels or university education LD is not likely) |  |  |
| Is the person known to the Community Learning Disability Team? |  |  |
| Does person have a consultant psychiatrist for learning disabilities? |  |  |
| Does person need assistance with transport? (Unable to get around independently?) |  |  |
| Does person have problems with simple numerical calculations? (i.e. ‘If I gave you £5 to buy milk. Milk costs £1.50 – how much is left?) |  |  |
| Does person have problems reading? (Reading a novel or newspaper usually rules out a learning disability.) |  |  |
| How does the person function in society? Does the person need support with activities of daily living? |  |  |

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| **Does the person have difficulty with:**  Communicating Yes  No  Writing Yes  No  Self-Care Yes  No  Living independently Yes  No  Interpreting social cues Yes  No  Controlling behaviour Yes  No  Co-ordinating movement Yes  No  Learning new skills Yes  No  Understanding new complex information Yes  No  Several ‘YES’ answers will often indicate the presence of a learning |

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| Factors which **MAY NOT** indicate a learning disability   * Normal development until other factors impact (before 18). * Diagnosis of ADHD, dyslexia, dyspraxia or Asperger’s * Successfully attend mainstream education without support. * Gained qualifications (GCSE and/or A ’Levels) * Able to function socially without support * Able to complete complex purchases e. g. buying a house. * Able to drive a car * Contact with mental health services * Recorded IQ above 70. | Factors which **MAY** indicate a indicate a learning disability   * Record of delayed development/ difficulties with social functioning daily living before 18. * Requires significant assistance to provide for own survival (eating &drinking, keeping self-clean, warm and clothed) and/or with social/ community adaptation (e.g. Social problem solving/reasoning). * NB need for assistance may be subtle. * Presence of all three criteria for LD i.e. Impairment of intellectual functioning/social adaptive functioning and age of onset. * Range of information presenting a picture of difficulties in a number of areas of function, not explainable by another ‘label’. * Contact with specialist Learning Disability consultant. |