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|  1. Client and Referrer details:  |
| Title: |  | Ethnicity: |  |
| First Name: |  | Language spoken: |  |
| Surname: |  | Interpreter required: |  |
| Address: |  | Carer name: |  |
| Telephone Number: |  | GP Name (referrer): |  |
| Date of Birth: |  | GP Practice: |  |
| NHS Number: |  | GP Telephone No: |  |
| Religion: |  | Date of referral: |  |

**We are a team composed of health professionals who work with adults with learning disabilities and complex health needs, who are unable to access mainstream health services (such as Extended Primary Care Physiotherapy or Occupational Therapy, CMHTs).**

Please note, the following individuals would not be eligible for our service:

* Client has a learning difficulty e.g. dyslexia, dyspraxia
* Clients seeking an IQ assessment without an identified unmet health need
* Client has an acquired brain damage / injury in adulthood (i.e. an injury NOT acquired before the age of 18)
* Client who has a physical disability but not a learning disability
* Client who has sensory impairment (visual or hearing) only

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| ANd9GcTwAompizLs5OPTDBbqRkOExD2LSpXnQkfcw7xkh1JHFI_pSGrUEw **2. Referral:** |
| **Please mark the service(s) you wish to refer in to:** |
| Art Therapy |  | Clinical Psychology |  | Community Nursing |  | Consultant Psychiatry |  |
| Occupational Therapy |  | Physiotherapy |  | Speech & Language Therapy |  |  |
| **Reason for referral and presenting problems i.e. what unmet health need(s) does the client have?**(include views of the client, carer & referrer): |
|  **kl;k** |
|  **3. Learning Disability Details:** (Please provide any diagnostic evidence and attach any relevant reports) |
| **What evidence is there that the person you are referring has a learning disability?**Please attach EMIS patient summary with a diagnosis of learning disabilities (problem list), or if this is not available, indicate the patient’s skills below: |
| **Activities** (Can / do they) | **✓** | **x** | **Memory**(Can they remember) | **✓** | **x** | **Life experiences**(Have / do they) | **✓** | **x** |
| Read |  |  | Significant things about themselves |  |  | Attended a special school |  |  |
| Write |  |  | Where they live |  |  | Have extra support e.g. 1:1 at school |  |  |
| Manage money |  |  | When they do things (their routine) |  |  | Attend a day centre for people with Learning Disabilities |  |  |
| Carry out personal care |  |  | What you have said |  |  | Live(d) in a hospital or a home for people with learning disabilities |  |  |
| Tell the time |  |  |  | Have people who support them (Carer/advocate) |  |  |
| Cook |  |  | Manage in social situations |  |  |
| Have difficulty communicating with others |  |  |  |
| **How does their learning disability impact on their health?** |

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| **C:\Users\Jamesr\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\HKDBU45H\Safety.png 4. Risk Factors: (To clients and others)** |
| **Factors relevant to visiting:** (E.g. Times at home, religious commitments, pets) |
| **Risk to others or self** (E.g. violence, self-harm etc.) |
| **C:\Users\Jamesr\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\O3AR0UF6\Consent-Forms.png 5. Consent** |
| **Does the client consent to this referral?** | Yes / No / Unable to elicit consent? |  |
| If no, please explain why the referral has been made:  |
| **Does the client consent for their information to be shared with external agencies.** | Yes / No / Unable to elicit consent? |  |
| **C:\Users\Jamesr\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\HKDBU45H\Signature.png 6. Signature** |
| Referrers Signature/electronic signature: |  | Date: |  |

**\*\*\*\*PLEASE ATTACH EMIS PATIENT SUMMARY\*\*\*\***

**and return to the Newham Health Team for People with Learning Disabilities at**



 **elt-tr.NewhamLD@nhs.net**