## Referral Doncaster Learning Disability Service

2 Jubilee Close, Tickhill Road Site, Balby, Doncaster, DN4 8QN

Tel: 03000 212878

**Email:** **RDASH.AdultLDServices@nhs.net**

SINGLE ACCESS REFERRAL FORM (SARF)

LEARNING DISABILITY SERVICES

**Please complete all relevant sections to ensure your referral is correctly allocated.**

|  |  |
| --- | --- |
| **CAPACITY, CONSENT & BEST INTEREST** | **If the person has capacity, has consent for this referral been obtained?****Has a best interest decision been documented?** |
| Capacity & consent: 🞎 YES 🞎 NO \*\*Please attach relevant MCA documents  |  Best interest decision: 🞎 YES \* 🞎 NO\*Please attach relevant documents  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SERVICE USER DETAILS** | NAME: Mr/Mrs/Miss/Ms |  | **MAIN CARER DETAILS** (e.g. family, key worker) | NAME |
| ADDRESS:POSTCODE: |  | ADDRESS:POSTCODE: |
| DATE OF BIRTH | TELEPHONE NUMBER |  | RELATIONSHIP TO SERVICE USER |
| NHS NUMBER  |  | TELEPHONE NUMBER | MOBILE NUMBER |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **REFERRER DETAILS** | NAME |  | **GP DETAILS**  | NAME  |
| ADDRESSPOSTCODE:  |  | ADDRESSPOSTCODE:  |
| PROFESSION (if applicable) |  |
| TELEPHONE NUMBER | MOBILE NUMBER |  | TELEPHONE NUMBER |
| DATE OF REFERRAL | Can the carer be contacted about this referral?  |  🞎YES |  |  |
|  🞎NO |

|  |
| --- |
| **DIVERSITY MONITORING** |
| **Gender (please circle)** | **Male**  | **Female**  | **Is this your birth gender** **Yes / No** | **Prefer not to say**  |
| **Religion** |  | **Prefer not to say** |
| **Relationship Status (please circle)** | **Single**  | **Living with partner** | **Married**  | **Civil Partnership**  | **Prefer not to say**  |
| **Ethnic Group**  |  | **Prefer not to say**  |

|  |  |
| --- | --- |
| **LEARNING DISABILITY SCREEN** | **The following questions provide further information relevant to learning disability** |
| abcdefghij | Does the person already have a diagnosis of learning disability? Does the person have communication difficulties?Does the person struggle to cope with tasks of daily living (e.g., self-care, budgeting, travel)?Does the person have difficulties in forming relationships?Does the person have difficulties in gaining employment?Has the person experienced a significant head injury, accident or illness resulting in damage to the brain, post 18 years of age? Does the person have a diagnosed mental health problem?Are they accessing mental health services?Does the person have a physical disability?Does the person have a sensory disability? | 🞎 YES 🞎 NO 🞎 YES 🞎 NO  🞎 YES 🞎 NO 🞎 YES 🞎 NO🞎 YES 🞎 NO🞎 YES 🞎 NO🞎 YES 🞎 NO🞎 YES 🞎 NO 🞎 YES 🞎 NO 🞎 YES 🞎 NO   |
| **LEARNING DISABILITY SCREEN**  | **Does the person display any other difficulties that lead you to believe they have a learning disability?** |
| 🞎 YES: The person has a specific condition associated with learning disabilityPlease give details:  |
| 🞎 YES: The person’s educational history/statement of need highlights learning disability Please give details:  |
| 🞎 YES: The person has received services from Learning Disability services in the past Please give details:  |
| **MEDICAL FACTORS & MEDICATION** | **Please provide a list of other medical problems and medications the person is taking.** Include information on all physical and mental health diagnoses & current medications (including known allergies and side effects). |
|  |

|  |  |
| --- | --- |
| **COMMUNICATION ISSUES** | **Does the person have any difficulties communicating?**  |
|  |

|  |
| --- |
| **REASONABLE ADJUSTMENTS – PLEASE STATE** |
|  |

|  |  |
| --- | --- |
| **RISK** | **Please provide information on the following areas of known risk.**  |
| 🞎 YES: Is the person vulnerable to risk? (e.g., self neglect, physical health, physical, sexual or financial abuse)? Please give details:  |
| 🞎 YES: Does the person pose a known risk to themselves (e.g., suicidal ideation, substance misuse, self harm)?Please give details:  |
| 🞎 YES: Does the person pose a known risk to other people (e.g., property damage, physical harm, sexual harm)? Please give details:  |
| 🞎 YES: Does the person pose a known risk to staff and professionals? Is a joint visit necessary?Please give details: |
| 🞎 YES: Does the person live in a household with children under the age of 18 years or have substantial access to their own or other children under the age of 18 years?Please give details: |
| 🞎 YES: Are there any known Safeguarding Children issues that you are aware of?Please give details: |
| 🞎 YES: Offending BehaviourPlease give details: |

|  |  |
| --- | --- |
| **OTHER AGENCIES/****PROFESSIONALS** | **Which other agencies or professionals are involved in supporting the person?**  |
|  |

|  |
| --- |
| **DETAILS OF CURRENT CONCERNS, RISK AREAS:****(Include details of previous offences/incidents with dates, risks to others and /or self, safeguarding concerns, targeted individuals, police contact). Engagement with services, destabilisers, substance misuse, dependents.** |
|  |

|  |
| --- |
| **WHAT OUTCOMES ARE YOU HOPING TO ACHIEVE?** |
|  |

|  |  |
| --- | --- |
| **SIGNATURE** | **Please sign and date this referral** |
| Name: ……………………………………………………………………………………… Date: ………………… |

 *NB – Please note to ensure there is no delay in processing this form*

 *all questions must be answered.*

 **Please return this form via email** **RDASH.AdultLDServices@nhs.net**