## Referral Doncaster Learning Disability Service

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SINGLE ACCESS REFERRAL FORM (SARF)

LEARNING DISABILITY SERVICES

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

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| **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 |

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| **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 |

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

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| **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** |

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| **LEARNING DISABILITY SCREEN** | | | | **The following questions provide further information relevant to learning disability** | |
| a  b  c  d  e  f  g  h  i  j | 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 disability  Please 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). | | | |
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| **COMMUNICATION ISSUES** | **Does the person have any difficulties communicating?** |
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| **REASONABLE ADJUSTMENTS – PLEASE STATE** |
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| **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 Behaviour  Please give details: | |

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| **OTHER AGENCIES/**  **PROFESSIONALS** | **Which other agencies or professionals are involved in supporting the person?** |
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| **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.** |
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| **WHAT OUTCOMES ARE YOU HOPING TO ACHIEVE?** |
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| **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**](mailto:RDASH.AdultLDServices@nhs.net)