##

## Appendix 5g - Referral North Lincolnshire Learning Disability Service



Community Learning Disability Health Team

Meridian House, Normanby Road

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**Adult Learning Disability Service**

SINGLE ACCESS REFERRAL FORM (SARF)

**Please Complete All Relevant Sections to Ensure Your Referral Is Correctly Allocated**

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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: | NHS NUMBER: |  | RELATIONSHIP TO SERVICE-USER: |
| TELEPHONE NUMBER: | ETHNICITY: |  | 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 |

 **PLEASE TICK THE SERVICES YOU WISH TO ACCESS**

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| Nursing pathways (ISS/Community)🞎  | Clinical Psychology (Currently N/A)🞎  | Psychiatry 🞎  |
| Speech & Language Therapy 🞎 Dysphagia🞎 Communication | 🞎 Physiotherapy🞎 Occupational Therapy  | Primary Liaison / Health Action Team🞎 |
| **SECTION A:**  | **This section should ONLY be completed if the person is already known to Adult Learning Disability Services and has an allocated Community LD Team worker** |
| **Please outline the nature and reason for your referral & tick the additional services you wish to access.**  |
| **Please go to Section B & complete questions 4 – 15** |

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| **SECTION B:**  | **This section must be completed if the person NOT known to the Community LD team or if they are not accessing adult Learning Disability Services.**  |
| **1** | **REASON FOR REFERRAL** | **Please outline the nature and reason for your referral.**  |
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| **2** | **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   |

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| **3** | **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:**  |
| **4** | **REFERRAL ONSET & CONTEXT** | **In relation to the reason for this referral, when were the person’s difficulties first observed? What life circumstances were they experiencing at this point in time?** |
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| **5** | **FAMILY BACKGROUND** | **Please provide information regarding the person’s family background.**  |
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| **6** | **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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| **7** | **PSYCHOLOGICAL ISSUES** | **Please describe any psychological, emotional and trauma related issues relevant to the person.** Include information on difficult life events here.  |
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| **8** | **COMMUNICATION ISSUES** | **Does the person have any difficulties communicating?**  |
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| **9** | **SENSORY & MOBILITY ISSUES** | **Does the person have a physical disability or sensory / mobility issues? Do they have difficulties with swallowing?** |
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| **10** | **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 others 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:** |

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| **11** | **FORENSIC ISSUES** | **Does the person have a history of offending? Please provide details.** |
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| **12** | **DIVERSITY** | **Does the person require an interpreter or access to any other communication supports in order to access this Service?** |
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| **13** | **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  |  Best Interest Decision: 🞎 YES 🞎 NO   |

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| **14** | **OTHER AGENCIES/****PROFESSIONALS** | **Which other Agencies or Professionals are involved in supporting the person?**  |
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| **15** | **SIGNATURE** | **Please sign and date this Referral** |
| Name: ……………………………………………………………………………………… Date: ……………………………… |

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| Referral Taken Over The Phone (Duty Officer):Name: ……………………………………………………………………………………… Date: …………………………… |