## 

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



Community Learning Disability Health Team

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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.** | |
| 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 |

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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: …………………………… |