# Lincolnshire Partnership

 **NHS Foundation Trust**

## LEARNING DISABILITY SERVICE REFERRAL FORM

**PLEASE COMPLETE ALL SECTIONS OF OUR REFERRAL FORM. INCOMPLETE FORMS WILL BE RETURNED. Please read the accompanying guidance or alternatively contact the hub team for your area to discuss.**

Date of Referral: .......................................... NHS No: ………………………………….

Who is filling this referral form in? …………………………………….

What is your relationship to the Person:………………………………

Contact details:

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| **Details about Person being referred:** |
| **Mr/Mrs/Ms** | **Surname:**  | **Forename:**  | **Date of Birth:**  |
| **Address:**  **Postcode:**  |
| **Telephone Number:** | **Who does the person live with:**  |
| **Have they lived in Lincolnshire since April 2016:**YES/NO | **If no what is their previous address:** |
| **Has the person had a diagnosis of Learning Disability?****YES/NO** **When:** | **Has the person had a diagnosis of a physical health problem.****YES/NO****When:** |
| **Has the person had a diagnosis of a mental health issue****YES/NO** **When:** | **Has the person had a diagnosis of autism?****YES/NO** **When:** |
| **GP name and address:** | **Details of other health professionals involved in the persons care** |
| **Next of Kin & Contact No:** | **Who is the most significant person involved in the persons care:** |
| **Do they receive paid care:****YES/NO** | **If so, how many hours:** |
| **Who provides that care:** | **Are any other people involved in persons care:** |
| **Is the person on CPA (Care Programme Approach) Yes / No****Name of care co-ordinator?****Date of last CPA review?** |
| **Does the person being referred know of this referral? YES/NO** **what is their view of this referral** | **Does the main carer/parent know of this referral? Yes / No****what is their view of this referral** |
| **Have they given their consent to being referred: YES/NO. If NO please explain the circumstances.** |
| **What is the persons preferred method of communication (please tick):****Phone Text letter email face to face** |
| **What are the specific communication needs for this person: please include all information about how they communicate with other people and barriers to communication that impact on their quality of life.** |
| ***In the following section please give as much information as possible to enable the team to respond appropriately to the person.***  |
| **What are the circumstances leading to this referral:****Please include information about the following:*** **Current psychological wellbeing**
* **Current relationships with others**
* **Current living arrangements**
* **Behaviours of concern**
* **Relevant historical information**
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| **What does the person want from this referral:** |
| **What are the expectations of the referrer**  |
| **What are the expectations of the persons carer**  |
| **What would you like the outcome of this referral to be:** |
| **How will you know when the outcome has been achieved:** |

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| **Please use this section to explain the risks the person currently presents. Please be as thorough as possible.**  |
| **What risk does the person pose to:-** |
| **Themselves:** |
| **Others:** |
| **How is this risk managed:-** |
| **What are the mitigating factors in managing this risk:** |
| **How can we help to keep this person safe:-** |
| **Before the team contacts the person what do we need to know to keep everyone safe:-** |
| **Signed : ………………………………………..** | **Dated : ……………………………………….** |

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| **Please ensure that all information asked for is provided to enable the referral to be appropriately processed**  |
| **Please send referrals to:**SPA Contact Centre, SycamoreUnit, Beacon Lane, Grantham, Lincolnshire, NG31 9DF.**E-mail:** lincs.spa@nhs.net **Telephone:** 0303 123 4000 **Fax:** 01476 579 011**\*Please note: Please ensure that you send personal identifiable information via secure methods.** |