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| **SECTION A** |
| Surname:       | Main Carer:       |
| Forename:       | Relationship:        |
| Male/Female:       | Address:       |
| Date of Birth:       |        |
| CHI Number:       | Post Code:       |
| Address:       | Tel No:       |
|        | Guardian Details (if applicable):       |
| Post Code:       | Type of Guardianship:       |
| Tel No:       |  |

|  |  |
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| **LIVING SITUATION:** | Lives independently [ ]  Supported Accom [ ]  With Carer [ ]  |
| **TYPE OF RESIDENCE:** | Mainstream housing [ ]  Sheltered housing [ ]  NHS facility [ ] Registered care home [ ] Mobile accommodation [ ]  Homeless [ ] Other[ ]  please state:       |

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| Referrer’s Name:      |
| Referrer’s Position:      |
| Address:        | Tel:       |
| Email Address:        | Date:       |

**Is the client able to agree to the referral? YES** **[ ]  NO** **[ ]**

**Has the client agreed to the referral? YES** **[ ]  NO** [ ]

**Has referral been agreed with Guardian / relative? YES** **[ ]  NO** [ ]

**Has the GP been notified of the referral? YES** **[ ]  NO** **[ ]**

**Does the person require an interpreter or access to other communication supports in order to access this service? (*Please detail*):**

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| **GENERAL PRACTITIONER** *(details of GP must be completed)* |
| **Doctor** | **Surgery** | **Telephone Number** |
|       |       |       |

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| **OTHER PROFESSIONALS, AGENCIES & SUPPORTS** (*only detail those not already mentioned above*) |
| **Name/Relationship** | **Address & email** | **Telephone Number** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

**Is the Person already known to the Adult Learning Disability Service? YES [ ]  NO [ ]**

If this is not in Fife, please specify where:

If **NO** - go to **SECTION B** If **YES -** go to **SECTION C**

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| **SECTION B** |
| **This section will help to establish if this is the appropriate specialist service for the person** | **Yes** | **No** |
| 1. Is this a transition referral from Child to Adult services?
 | [ ]  | [ ]  |
| 1. Has a diagnosis of learning disability already been made by a health professional?
 | [ ]  | [ ]  |
| If you have answered “No” to question above: Is this referral for a Learning Disability Assessment? | [ ]  | [ ]  |
| 1. Does the person have reduced ability to understand new or complex information?
 | [ ]  | [ ]  |
| 1. Does the person have difficulty coping independently with tasks of daily living?
 | [ ]  | [ ]  |
| 1. Has the person experienced a significant head injury, accident or illness resulting in damage to the brain, post 18 years of age?
 | [ ]  | [ ]  |
| 1. Does the person have a diagnosed mental health problem
 | [ ]  | [ ]  |
| 1. Is the person accessing mental health services?
 | [ ]  | [ ]  |
| 1. Does the person have a physical disability?
 | [ ]  | [ ]  |
| Please use this space to expand on any answers above:       |
| **Does the person display any other difficulties that lead you to believe they have a Learning Disability?** (e.g. educational history, employment history, a specific condition associated with having a learning disability). Please give details:       |

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| **SECTION C** |
| **Please answer these questions as fully as you can.**  |
| Is this referral for a Capacity Assessment? YES [ ]  NO [ ] Does this referral relate to an AWI matter? YES [ ]  NO [ ]  |
| **Please give a background history for the person *(include medical, social, family situation, environmental and significant life events)***      |
| **What has changed recently that has prompted you to make this referral now?** ***NB- Please note here if there is something specific you think the team could do which would help***      |
| **What impact have these changes had on the client’s life?**      |
| **What has been tried already and what difference did it make?**       |

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| **SECTION D** |
| **Risk** | **Yes** | **No** |
| 1. Is the person a risk to themselves? (e.g. self harm, suicidal ideation, substance misuse, falls)
 | [ ]  | [ ]  |
| 1. Does the person pose a known risk to other people including staff and professionals?
 | [ ]  | [ ]  |
| 1. Are there any other risk factors our service should be aware of? (pets, other household residents, environmental etc)
 | [ ]  | [ ]  |
| **NB:** If you have answered yes to any of the above questions someone will contact you via telephone to get further details. |

**PLEASE RETURN TO:** Referral Coordinator

 Community Learning Disabilities Service

 Lynebank Hospital

 Halbeath Road

 DUNFERMLINE

 KY11 4UW

 **Email: *Fife.LDReferrals@nhs.scot***

 **Tel No.** 01383 565230 (x35230)