|  |  |
| --- | --- |
| **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: |  |

|  |  |
| --- | --- |
| **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: |

|  |  |
| --- | --- |
| 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*):**

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

|  |  |  |
| --- | --- | --- |
| **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**

|  |  |  |
| --- | --- | --- |
| **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: | | |

|  |
| --- |
| **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?** |

|  |  |  |
| --- | --- | --- |
| **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)