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## Learning Disability Specialist Health Team Referral Form

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| Email to: [CTALDHealthReferrals@SomersetFT.nhs.uk](mailto:CTALDHealthReferrals@SomersetFT.nhs.uk)  **Please complete this referral form in FULL to avoid delay as it will be returned to you for further information.**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **CONSENT**  **IMPORTANT - If the client is able to consent to the referral, but has not done so, we are unable to take this referral forward.** | | | | | | **Is the client able to give consent to this referral?** | Yes |  | No |  | | **If yes, have they consented to this referral?** | Yes |  | No |  | |

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| CLIENT DETAILS | | | | |
| **Client’s Name and Address:** |  | | **D.O.B.** |  |
| **NHS No.** |  |
| **Client’s GP, practice and Telephone No.** |  | | **Ethnicity:** |  |
| **Client Tel No.** |  |
| **Marital Status:** |  | | **Known Allergies/Adverse Reactions:** |  |
| **Next of Kin: Name and Contact Details:** |  | | **Medical Diagnosis/es:** |  |
| **Do they smoke?** |  | | **Do they have a Hospital Passport?** | Yes/No |
| **Have they had an annual health check?** | Yes/No  If yes, give date: | |  |  |
| **REFERRER DETAILS** | | | | |
| **Referred by: name, role and postal address:** |  | | | |
| **Email address and Phone No:** |  | | **Referral date:** |  |
| **FAMILY INVOLVEMENT** | | | | |
| **What family involvement is there?** | |  | | |
| **If in residential care/supported living, how much involvement and updates do the family want/expect?** | |  | | |
| **REFERRAL REASON** | | | | |
| **What are the current difficulties and what are you asking our service to provide?** | | | | |
| **Other People Involved in Support** *e.g: social worker, day service, safeguarding, current medical investigations etc.* | | | | |
| **Medical History*:*** *Including diagnosis of a Learning Disability, current and past medication, any physical health problems etc.*  **Medication: Please complete this section in full**  **Medications**   |  |  | | --- | --- | | **Medication Name** | **Current dosage** | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | | | | | |

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| **ACCOMMODATION – WHERE DO THEY LIVE?** | | | |
| Private Accommodation, with family |  | Residential Care |  |
| Supported Living |  | Nursing Care |  |
| **WHO FUNDS THEIR SUPPORT?** | | | |
| Somerset Local Authority |  | Other Local Authority |  |
| Somerset CCG |  | Other Health Funding |  |
| Joint Health and Local Authority |  |  |  |
| **EMPLOYMENT** | | | |
| Long-term sick or disabled |  | Full-time employment |  |
| Part-time Employment |  | Unpaid, Voluntary work |  |
| **POWER OF ATTORNEY** | | | |
| Does the person have a Power of Attorney? | Yes/No | | |
| If YES, is this for Health and Wellbeing and/or for Property and Finances? |  | | |