HAVERING COMMUNITY LEARNING DISABILITY TEAM
EXTERNAL REFERRAL FORM

PLEASE COMPLETE FORM AS FULLY AS POSSIBLE: All bold boxes indicate mandatory fields that must be completed for a referral to be processed. Please note that if fields that are not bold are not filled in this may also cause a delay in processing.

Definition of Learning disability
ICD-10: Two main components must be present, namely low cognitive ability and diminished social competence. These are both profoundly affected by social and cultural influences in the way that they become manifest.
DSM-IV: Learning Disorders are diagnosed when the individual's achievement on individually administered, standardised tests in reading, mathematics, or written expression is substantially below that expected for age, schooling, and level of intelligence.

In both definitions the person must have experienced problems before the age of 18.

Factors which MAY indicate a learning disability

-Record of delayed development/difficulties with social functioning & daily living before 18.

-Requires significant assistance to provide for own survival (eating & drinking, keeping self clean, warm and clothed) and/or with social/community adaptation (e.g. Social problem solving/reasoning). **NB** need for assistance may be subtle.

-Presence of all three criteria for LD i.e. Impairment of intellectual functioning/social adaptive functioning and age of onset.

-Range of information presenting a picture of difficulties in a number of areas of function, not explainable by another 'label' Contact with specialist LD consultant

TITLE: **NAME:** **DOB:** **ADDRESS:** **Email address**			
TEL NO:	**AIS NO:**	**NHS NO:**	**RiO NO:**
NATIONAL INSURANCE NO			
RELIGION / CULTURE:	**ETHNICITY:**		
GP NAME: **Address:** **Telephone No:** **Email:**			
CONSULTANTS INVOLVED:			
NEXT OF KIN: **(State relationship to client)**		**ADDRESS & POST CODE:**	
TEL NO:		**EMAIL ADDRESS**	
LANGUAGE / COMMUNICATION SYSTEM USED:		**INTERPRETER REQUIRED:**	

Are there any hazards in the person's property? i.e. dangerous pets etc. **Yes** ☐ **No** ☐
Give Details

Diagnosis of a Learning disability	**No** □	**Yes** □	**date:**	**by who:**

Diagnosed Health Needs	**Yes**	**No**	**Date**	**Details/Comments**
Mental health				
Autism				
Any Syndrome				
Epilepsy				
Continence				
Diabetes				
Physical Disability (specify)				
Sensory Disability (specify)				
Behavioural issues (specify)				

Please indicate professional/s they/you have received input from	**Most recent date**	**Name of professional**	**Contact details**
Psychiatry			
Psychology			
Occupational Therapist			
Physiotherapist			
Speech and Language Therapist			
Dietician			
Specialist Nurse (specify)			
Social Worker			

Any other agencies Please list:

……..
……..
……..

Has the referred person been admitted to any Learning Disability in-patient unit?
Yes □ **No** □ **e.g. Moore Ward (Goodmayes Hospital).**

If Yes Please state where/When: _____

Is the referred person on any of the following medications:

Anti-epileptic medication such as:
Carbamazepine □ Phenytoin □ Sodium Valproate □ Lamotrigine □
Keppra □ Other □

Anti-Cholinergic Medication such as:
Procyclidine □ Other □

Anti-Psychotic medication such as:
Chlorpromazine □ Risperidone □ Olanzapine □ Amisulpride □ Clozapine □ Other □

Anti-Depressant Medication such as:
Venlafaxine □ Prozac □ Sertraline □ Paroxetine □ Other □

CURRENT SITUATION: (up to date specific info on concerns /need)

REASON FOR REFERRAL: (what exactly are you requesting)

WHAT ARE YOUR EXPECTATIONS & DESIRED <u>OUTCOMES</u> FROM THE TEAM:

PREVIOUS CONTACT WITH THE TEAM: (when & who)

Is this the same need or difficulty:

IS THE PERSON AWARE OF THIS REFERRAL:
If No, please give reasons why not

was consent gained? If Yes, how?

REFERRER'S NAME: **Professional Designation &Team or Relationship:**

ADDRESS/EMAIL ADDRESS & TEL NO:

SIGNATURE: **DATE OF REFERRAL:**

BS Officer Use Only **- Date referral received by CLDT ……..**

Known to CLDT ☐ Unknown to CLDT ☐ Transition ☐

TO BE COMPLETED BY LEARNING DISABILTY DUTY: TO ESTABLISH IF REFERRAL IS URGENT OR NON-URGENT AND IF REFERRAL IS APPROPRIATE FOR LD SERVICES

DATE RECEIVED BY DUTY: ……..

NAME ……. Discipline……...

PRIORITY: NON-URGENT ☐
URGENT ☐

Reason urgent:……

REFERRAL DEEMED: APPROPRIATE ☐

INAPPROPRIATE ☐ Reason……..

UNDECIDED ☐ Reason……..

OUTCOME: Passed on to referral meeting for allocation ☐
Issue resolved by Duty Worker ☐
Evidence of LD Yes ☐ No ☐
Further information required Yes ☐ No ☐

Any Supporting evidence:
GP letter/diagnosis ☐
Psychology reports ☐
Education reports ☐
Previous involvements ☐
Other/RIO ☐

TO BE COMPLETED BY BSO:

RESPONSE LETTER SENT: ☐ Accepted
☐ Not accepted
☐ Screening Appointment

SIGNED: …….. DATE:……

Please return form by email to: CLDTReferrals@havering.gov.uk

Or by post/fax: Havering Community Learning Disability Team, The Hermitage, Billet Lane, Hornchurch, Essex, RM11 1XL. Tel: 01708 433446 / Fax: 01708 434358