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| **ADDITIONAL GUIDANCE FOR COMPLETING A REFERRAL FORM TO THE**  **NEWHAM HEALTH TEAM FOR ADULTS WITH LEARNING DISABILITIES**   * It is *essential* that this form is completed as thoroughly as possible so that people with learning disabilities with unmet health needs receive the support they need as soon as possible * **Referral forms with insufficient information will be returned for you to complete before the referral can be accepted** * **we do not accept fax referrals**   If you would like further support or discuss your referral please contact the team on **020 7059 6600** | | | | | | | | | | | | |
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| Client Details: | | | | | | | | | GP Details: | | |  | |
| **Title:** | |  | **Gender:** | | Male Female | | | | **Name:** |  | | |  |
| **First Name:** | |  | | | | | | | **Address:** |  | | |  |
| **Surname:** | |  | | | | | | |  |  | | |  |
| **Address:** | |  | | | | | | |
| **Telephone No:** |  | | | |
| **Referrers Details:** | | | | |
| **Telephone No:** | |  | | | | | | |
| **Date of Birth:** | |  | | | | **Age:** | |  | **Name:** | |  | | |
| **NHS No:** | |  | | | | | | | **Designation:** | |  | | |
| **Language:** | |  | | | | | | | **Organisation:** | |  | | |
| **Interpreter Required:** | | Yes  No | | **Advocate Required:** | | | Yes  No | | **Contact Details:** | |  | | |
| **Ethnicity:** | |  | | | | | | | Image result for calendar  **Date:** | |  | | |
| **Religion:** | |  | | | | | | |

**We are a team composed of health professionals who work with adults with learning disabilities and complex health needs, who are unable to access mainstream health services.**

Please note, the following individuals would not be eligible for our service:

* Client has a learning difficulty e.g. dyslexia, dyspraxia
* Client has an acquired brain damage/ injury in adulthood (i.e. an injury NOT acquired before the age of 18)
* Client who has a physical disability but not a learning disability
* Client who has sensory impairment (visual or hearing) only

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| **kl;k** | | | | | | | | | | | | | | | | | |
| Image result for question  **Referral Details:** | | | | | | | | | | | | | | | | | |
| **Please tick the service(s) you wish to refer in to:** | | | | | | | | | | | | | | | | | |
| Art Therapy | |  | Clinical Psychology | | | |  | Community Nursing | | | | |  | Consultant Psychiatry | |  | |
| **Occupational Therapy** | |  | Physiotherapy | | | |  | Speech & Language Therapy | | | | |  |  | |  | |
| **Reason for referral and presenting problems i.e. what unmet health need(s) does the client have?**  (include views of the client, carer & referrer**):**  **Why we want this information?**   * We need to establish whether we are the correct team to support the person you are referring * Having thorough information enables us to make decisions about the right disciplines to get involved * We need to be able to understand what the problem is (unmet health need) * We need to know why it is a problem *now* e.g. have there been any changes? * To help to identify risks so we can respond in a timely manner**.**   **Important things to include:**   * **A description of what the problem(s) / concerns is/are e.g.**   + What is happening or what is the problem?   + How frequently does it happen?   + Where does it happen?   + Who is involved?   + Why do you think it happens?   + Who is concerned about the problem? * **What are the consequences of the problem(s) / concern(s)** * e.g. no longer attends activities/clubs/ placements due to this issue * not able to access GP/Hospital appointments * health needs not met / not managed * **Information about any risks the person or their environment has to themselves and/or others, please include frequency and severity** * **Details of the service user’s different environments** e.g. do they attend college? Live in a residential home? Attend clubs? | | | | | | | | | | | | | | | | | |
| **kl;k** | | | | | | | | | | | | | | | | | |
| Image result for reports  Don’t forget to attach reports or diagnosis letters with completed referral form  **Learning Disability Details:** | | | | | | | | | | | | | | | | | |
| **What evidence is there that the person you are referring has a learning disability?**  **Please attach a report or letter with a diagnosis, or if this is not available, complete the boxes below** | | | | | | | | | | | | | | | | | |
| **Activities** (Can / do they) | | | | **✓** | **x** | **Memory**  (Can they remember) | | | | **✓** | **x** | **Life experiences**  (Have / do they) | | | **✓** | | **x** |
| Read | | | |  |  | Significant things about themselves | | | |  |  | Attended a special school | | |  | |  |
| Write | | | |  |  | Where they live | | | |  |  | Have extra support e.g. 1:1 at school | | |  | |  |
| Manage money | | | |  |  | When they do things (their routine)  Please ensure you complete the above boxes to help us to determine eligibility for our service and prevent unnecessary delays | | | |  |  | Attend a day centre for people with Learning Disabilities | | |  | |  |
| Carry out personal care | | | |  |  | What you have said | | | |  |  | Live(d) in a hospital or a home for people with learning disabilities | | |  | |  |
| Tell the time | | | |  |  |  | | | | | | Have people who support them (Carer/advocate) | | |  | |  |
| Cook | | | |  |  | Manage in social situations | | |  | |  |
| Have difficulty communicating with others | | | |  |  |  | | | | | |
| **How does their learning disability impact on their health?**  **Why we need section completed?**  The Newham Health Team for Adults with Learning Disabilities accepts referrals for people with **severe to profound learning disabilities who have an unmet health need**.  We may also work directly with adults with mild and moderate learning disability **if their clinical presentation is complicated by their Learning Disability** **to the** **extent that it would prevent them from accessing mainstream services even with reasonable adjustments e.g. if they display behaviours that challenge** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Description: school%20building%20black%20and%20white**Medical History:** | | | | | | | | | | | | | | | | | |
| **Diagnosis and any current medication:**  GPs: – please attach current & past medical history from EMIS | | | | | | | | | | | | | | | | | |
| **Past Medical History:** (Please include psychiatric history and recent hospital admissions if appropriate) | | | | | | | | | | | | | | | | | |
| **Allergies:** (Please state if none, do not leave blank) | | | | | | | | | | | | | | | | | |
| **kl;** | | | | | | | | | | | | | | | | | |
| ANd9GcTb1WcCfb2zAAGWYuQif3UXTaW62Xw-zjmM_AEvKNV4ZMqj7UpX**Key People:** | | | | | | | | | | | | | | | | | |
| **Main Carer:** |  | | | | | | | | **Next of Kin:** | | |  | | | | | |
| Relationship: |  | | | | | | | | Relationship: | | |  | | | | | |
| Contact Details: | It is important to list key people together with their contact details so we can engage with the person’s social and health networks, if appropriate. | | | | | | | | Contact Details: | | |  | | | | | |

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| ANd9GcTpeXlajob1Upj0qiTc3OvyRAHvTY0JkYkgm2TG5QVRXeW4h4m4W06QrI8**Other Persons / Agencies involved in clients care:** (E.g. Social worker, day centre, health care professionals) | | |
| **Name** | **Role** | **Contact Details** |
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| **kl** | | |
| Description: https://encrypted-tbn0.gstatic.com/images?q=tbn:ANd9GcRvbZtH4CqNhBkRlx0lF9OkNWOOtcL2mR_X3cki0F5xwMLROavyaQ**Risk Factors: (To clients and others)** | | |
| **Factors relevant to visiting:** (E.g. Times at home, religious commitments, pets) | | |
| **Risk to others or self** (E.g. violence, self-harm etc.) | | |

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|  | **Consent: CONSIDER MENTAL CAPACITY ACT** | | | | | | |
| **Does the client consent to this referral?** | | Yes |  | No |  | Does not have capacity |  |
| If person does not have capacity please explain how capacity was assessed and how decision was reached to refer to this team  It is essential to explain how capacity was assessed, whether this referral was made in the person’s best interests and who was involved in this process | | | | | | | |
| **Does the client consent for their information to be shared with external agencies.** | | Yes |  | No |  | Does not have capacity |  |

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| **Signature** |
| Referrer Signature: |

Examples

Joe Bloggs has become verbally and physically aggressive to himself and staff in the last month(hitting others, kicking others, slapping face hard and biting own fingers) This happens daily and is increasing in both the number of times it happens but also how hard he hits his face and you can see red marks after). This happens at home (supported living)and his day centre but not when he goes to his football group

I would like to refer Jane Doe to SLT to assess her communication skills. She is non-verbal and is getting angry (hitting others and herself) when asked what she wants to do when she gets home from college