Person's Name: DOB:

Office Use only:
Date received:

Learning Disabilities Health Team Referral Form

Berkshire Healthcare
NHS Foundation Trust

Referral Forms to be sent to the relevant Community Team for People with Learning Disabilities (CTPLD)

Date of Referral:

Details of person being referred		
Title:	**Forename:** (include preferred names if relevant)	**Surname:**
Date of Birth:		**NHS ID and/or RIO ID and/or Social Care ID:**
Main Address:		**Temporary address / respite address:**
Your phone number:		**Contact person and number** (if different to referred person):

Email:	**Communication Preferences**
Name of main carer / next of kin, and relationship to person being referred:	**Face to Face appointments**: British Sign Language ☐ Lip Reading ☐ Advocate/Carer required ☐ Makaton sign ☐ **Making Contact:** Email ☐ Text ☐ Phone ☐ Other ☐
Address: **Telephone number:**	**Written:** Large font ☐ Email ☐ Easy Read ☐ Braille ☐ Audio tape ☐ Pictures/photo/ symbols ☐
GP name & surgery:	**Duplicate Information to:** Formal Carer ☐ Parent/Guardian ☐ Other ☐
GP phone number	

Does this person have learning disabilities?
Main diagnosis and other health conditions (and any other impairments):
Current medication:
Any known allergies or sensitivities:

Does this person have epilepsy?	Yes ☐	No ☐
What is the person's: Weight…………….. Height…………………… This information must be completed if the referral is for the Dietitian, Nurses or Speech and Language Therapist (eating & drinking assessments)		
Does this person smoke?	Yes ☐ If yes would they like to be referred to the Smoking Cessation Service Yes ☐ No ☐	No ☐

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Consent

Is the referred person aware of this referral?

Yes ☐ No ☐

Has the referred person consented to this referral?

Yes ☐ No ☐

If no – please state why*? If person lacks capacity, has a Best Interest decision been made – provide details*

Care manager/local authority holding responsibility:

Telephone number:

Reason For Referral

Please give a summary of the reason why you / the person being referred needs support from a Health and Social Care service in CTPLD. Please be specific and attach any relevant information to help with the referral.

Who do you think the referral is for?

☐ Challenging Behaviour Specialist ☐ Dietitian ☐ Health Support Worker ☐ Nursing
☐ Occupational Therapy ☐ Physiotherapy ☐ Psychiatry ☐ Psychology
☐ Speech and Language Therapy ☐ Social Care Referral (East Berkshire only)

What are the person's desired outcomes for this referral?

What supporting documents / reports are attached? (e.g. psychological assessment; health information; educational information etc.)

Risk Factors: Please tick

	Past	Present	Not Known		Past	Present	Not Known
Deliberate Self-Harm	☐	☐	☐	**Forensic History**	☐	☐	☐
Suicide	☐	☐	☐	**Substance Misuse**	☐	☐	☐
Self-Neglect	☐	☐	☐	**Housing Problems**	☐	☐	☐
Abuse from Others	☐	☐	☐	**Non-Compliance with Treatment**	☐	☐	☐
Violence to Others (verbal) (including professionals)	☐	☐	☐	**Has served in the armed forces?**	☐	☐	☐

Referrer's Details:

Name of referrer:

Professional role / support to the person:

Address:

Signature of referrer:

Telephone Number:

Email:

Other Services Involved

Other Professionals involved and their roles in supporting the service user (please include contact details)

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Person's Name: DOB:

Living environment (current accommodation):

Own Home ☐ Family/Carers Home ☐ Residential ☐ Supported Living ☐ Other (Please state)………………… ☐

Settled Accommodation Indictor:
Is permanent residence settled or non-settled? Settled ☐ Non-settled ☐

Employment status:

Employed ☐ Unemployed ☐ Voluntary Work ☐ Supported Work ☐ Student ☐ Not Applicable ☐ Not Known ☐

Weekly hours worked? ☐

Demographic Details

Ethnicity ***(please tick)***

Asian Bangladesh	☐	Ethnic Other	☐
Asian Indian	☐	Mixed White & Asian	☐
Asian Other	☐	Mixed White & Black African	☐
Asian Pakistani	☐	Mixed White & Caribbean	☐
Black African	☐	Mixed Other	☐
Black Caribbean	☐	White Other	☐
Black Other	☐	White Irish	☐
Chinese	☐	White British	☐
Declined to answer	☐		

Marital Status ***(please tick)***

Civil Partnership	☐	Divorced / Person who's Civil Partnership is dissolved	☐
Married	☐	Not Disclosed	☐
Separated	☐	Single	☐
Widowed/Surviving Civil Partner	☐		

Religion: ***(please tick)***

Atheist	☐	Judaism	☐
Buddhism	☐	Islam	☐
Christianity	☐	Sikhism	☐
Hinduism	☐	Any Other belief	☐
Prefer not to say	☐		

Does this person have a chronic illness or disability? Yes ☐ No ☐ Prefer not to say ☐

Along term medical condition ☐ Mobility problems ☐ Sight loss ☐ Hearing loss ☐

A Learning Disability ☐ Mental ill health ☐ Other (Please state)………………………

Which of the following best describes – gender?
i) Male ☐ ii) Female ☐
iii) Prefer to self-describe ☐ iv) Prefer not to say ☐

Which of the following best describes – sexual orientation?
i) Straight / heterosexual ☐ ii) Lesbian/ Gay ☐ iii) Bisexual ☐
iv) Prefer to self-describe ☐ v) Prefer not to say ☐

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Please use for any additional information you feel would be helpful

Bracknell CTPLD 2nd Floor, North Time Square Market Street Bracknell RG12 1JD Call: 01344 354 466 Duty.CTPLD@Bracknell-Forest.gov.uk	Slough CTPLD Observatory House 25 Windsor Road Slough SL1 2EL Call: 01753 475 111 CTPLD.Duty@slough.gov.uk	WAM CTPLD St Marks Hospital St Marks Road Maidenhead SL6 6DU Call: 0118 904 2834 CTPLD@rbwm.gov.uk
Wokingham CTPLD Erlegh House Earley Gate Whiteknights Road Reading RG6 6BZ Call: 0118 904 7196 WokinghamCTPLD@berkshire.nhs.uk	Reading CTPLD Erlegh House Earley Gate Whiteknights Road Reading RG6 6BZ Call: 0118 904 7195 ReadingCTPLD@berkshire.nhs.uk	Newbury CTPLD West Berkshire Council Offices Market Street Newbury RG14 5LD Call: 0118 904 7194 NewburyCTPLD@berkshire.nhs.uk