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|  | **Sirona Adult Learning Disability Health Service****Referral Form** |  |

If you need help to complete this form; please call your local advice line:

Bristol: 0117 908 5000

North Somerset: 01275 546888

South Gloucestershire: 0300 124 5888

***Please complete all sections of this form; otherwise the referral will be returned***

**A learning disability** is a significant, lifelong condition that starts before 18 years. It affects development and leads to help being needed to: Understand information; Learn skills; Cope independently.

**Mainstream health services can meet the needs of most people with a learning disability**. We offer specific specialist interventions and may not always be the best service for the referral need. In this situation we will offer advice on other services and reasonable adjustments.

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| 1. **CONSENT *These questions must be completed* (Please tick (**✓**) appropriate box)**
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|  |  |  |  |  |  |
| **Can the person agree to the referral?** | **Yes** |  | **No** |  |  |
|  |  |  |  |  |  |
| **If ‘Yes’, has the client agreed to the referral?** | **Yes** |  | **No** |  |  |
|  |  |  |  |  |  |
| **If ‘No’, has referral been agreed in their best interest?** | **Yes** |  | **No** |  |  |
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| 1. **ABOUT THE PERSON**
 |
| **(Please tick (✓) appropriate box)** |  |
| **Title:** | **Mr** |  | **Mrs** |  | **Miss** |  | **Ms** |  |  | **NHS Number:** |  |
|  |  |  |
| **Name:** |  | **Date of Birth:** |  |
| **Address:** |  | **Ethnicity:**  |
|  |
|  | **Religion:** |
| **Telephone Number:** |  | **For dietetics referrals please complete:****Height:** **Weight:**  |
|  |
| **Gender:** | **M** |  | **F** |  | **Other:** |  |  |
| If ‘Other’, please specify:  |
| **Relevant Medical Information:**  |

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| 1. **REFERRER AND GP DETAILS**
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| **Referrer Details:** | **GP Details:** |
| **Name:** |  | **Name:** |  |
| **Job Role:** |  | **Practice Address:** |  |
| **Address:** |  |  |
|  |  |
| **Telephone No:** |  | **Telephone No:** |  |
| **Email:****Date of referral:**  |  |  |  |

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| 1. **EVIDENCE OF LEARNING DISABILITY (Please tick (✓) appropriate box)**
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| **Does the person have an established learning disability?** | **Yes** |  | **No** |  |  |
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| **If ‘Yes’, please give details:**  |
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| **If ‘No’, what are your reasons for believing the person has a learning disability:** |
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|  |
| **Education: statement of educational needs / EHCP / attended special school**  | **Yes** |  | **No** |  |  |
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| **Employment: not been in long-term, skilled or unskilled employment** | **Yes** |  | **No** |  |  |
|  |
| **Daily living skills: needs support with cooking, cleaning, shopping, finances**  | **Yes** |  | **No** |  |  |
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| ***Please give details:*** |
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| **How does the person’s learning disability prevent them from accessing mainstream services?** Please state what reasonable adjustments have already been made – e.g. longer appointment times, accessible information, involvement of family carers) |
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| 1. **REASON FOR REFERRAL TO THE SIRONA LEARNING DISABILIY HEALTH SERVICE**
 |
| * What is the health need
* What is the outcome the person wishes to achieve
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| 1. **PLEASE RETURN THIS FORM BY Email or Post To:**
 |
| **Sirona Adult Learning Disability Health Service**New Friends HallHeath House Lane,Stapleton, Bristol BS16 1EQ |
| **Email:** Sirona.CLDTref@nhs.net  |