



**HARINGEY COMMUNITY LEARNING DISABILITIES TEAM**

**REFERRAL FORM**

**PART ONE: TO BE COMPLETED FOR ALL REFERRALS**

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| **Date of Referral:**  | **Referral Received (office use):**   |

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| **DETAILS OF PERSON BEING REFERRED** |
| **First Name:**   | **Family Name:**   |
| **Male** [ ]  **Female** [ ]  | **Date of Birth:**   |
| **Address:**  **Postcode:**   | **Telephone No:**   |
| **NHS No:**   |
| **Mosaic No.** (office use)**:**   |
| **FIRST LANGUAGE:**   | **Is an interpreter required?** **Yes** [ ]  **No** [ ]  |
| **GP:**  **Address:**  **Telephone No:**  |
| **DETAILS OF PERSON MAKING THE REFERRAL** |
| **Name:**   | **Relationship to the person being referred:**   |
| **Address:**   |
| **Contact No:**   | **Email:**   |

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| **Has the person consented to this referral?** Yes [ ]  No [ ]   |
| **Is the person a British National or UK Citizen?****Yes** [ ]  **No** [ ]  **(Please provide details of immigration status)**  .*This does not mean we will not assess you but could affect the services that you are entitled to.* |
| **Does the person have a diagnosis of a Learning Disability?** A learning disability diagnosis requires that a person meets all three of the following criteria:1. A significant cognitive impairment i.e. an IQ below 70
2. A significant impairment in daily living skills
3. The onset of disability started before adulthood, with a lasting effect on development

**Yes** [ ]  **No** [ ] *If yes, please provide details e.g. Down Syndrome, Retts Syndrome diagnosed by GP, Consultant and date of IQ assessed as below 70 and please provide reports*  |
| **Is the person known to the Haringey Community Learning Disabilities Team?** Yes [ ]  No [ ]  |
| **Is the person known to another Learning Disability Team?** Yes [ ]  No [ ] *If yes, please give details*   |

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| **REASON FOR REFERRAL** |
| New referral (Learning Disabilities Team Health and Social Care Assessment required) [ ]  Please also complete part two of the referral formUrgent Referral (evidence of severe risk to self or others) [ ] Mental Health/Challenging Behaviour Pathway [ ] Physical Health Pathway [ ] Other (please specify) [ ]  |
| **Specific Reason for referral***Please provide clear information about why this referral is being made and what support is required e.g. concerns about the person’s behaviour or their mental or physical health, risks or support needs etc.*  |

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| **ARE THERE ANY RISKS OR SAFEGUARDING CONCERNS?**  |
| **Is the person at risk of harm e.g. self-harm, harm from others?****Yes** [ ]  **No** [ ] *If yes, please provide details:*  |
| **Are there any risks around meeting with this person e.g. risk of harm to others, environmental risks at home address?****Yes** [ ]  **No** [ ] *If yes, please provide details:*  |

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| **WHAT IS THE BEST WAY TO MAKE CONTACT WITH THIS PERSON?** [ ]  Telephone person directly [ ]  Telephone carer (please give details) [ ]  Email (please give details) [ ]  Written letter (please give details)[ ]  Easy read information [ ]  Other (please give details) |
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**PLEASE RETURN THIS FORM TO: Haringey Learning Disabilities Partnership, 2nd Floor, River Park House 225 High Road London N22 8HQ**

**Tel: 020 8489 1384 Fax: 020 8489 1327 Email:** **HLDP@haringey.gov.uk**

**PART TWO: ALL NEW REFERRALS MUST COMPLETE THE FOLLOWING SECTIONS**

**These additional questions will help us to decide if a person meets the eligibility criteria for our service.**

A learning disability diagnosis requires that a person meets all three of the following criteria:

1. A significant cognitive impairment (i.e. an IQ below 70)
2. A significant impairment in daily living skills (e.g. washing and dressing, cooking and cleaning, money skills and travel)
3. The onset of disability is considered to have started before adulthood, with a lasting effect on development.

This does not include people with specific learning difficulties (e.g. dyslexia, dyspraxia) or people who have sustained a cognitive impairment in adulthood (e.g. brain injury, stroke, dementia) as there are other services available for people with these difficulties.

**Please answer all the following questions or your referral may be returned.**

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| **Did the person attend any special schools or have any additional support in mainstream school?**Is there a Statement of Special Educational Needs (SEN) or Education Health and Social Care Plan (EHCP)? **Yes** [ ]  **No** [ ] *If yes, please provide details and send a copy of any SEND/ECHP documentation*  |
| **Does the person have any qualifications e.g. GCSEs, BTEC etc?****Yes** [ ]  **No** [ ] *If yes, please provide details of course, grade and level of qualification*  |
| **Has the person ever had or are they in paid or voluntary employment?** **Yes** [ ]  **No** [ ] *If yes, please provide details e.g. job role, any support required*  |
| **Has the person had a brain injury which has caused cognitive impairment**? (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life)? **Yes** [ ]  **No** [ ] *If yes, please provide details e.g. type of injury, age at which occurred*  |
| **Does the person have physical disabilities?****Yes** [ ]  **No** [ ] *If yes, please provide details*  |
| **Does the person have physical or mental health problems or diagnoses?****Yes** [ ]  **No** [ ] *If yes, please provide details*  |
| **Does the person take medication?****Yes** [ ]  **No** [ ] *If yes, please provide details of medication and whether they are able to administer this themselves or require support*  |
| **Is the person in receipt of benefits?** **Yes** [ ]  **No** [ ] *If yes, please provide details and rates e.g. PIP, DLA, ESA, JSA*  |

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| **PLEASE TELL US ABOUT THE PERSON’S DAILY LIVING SKILLS** What can they do for themselves? What do they need help with? What type of help do they need? |
| **COMMUNICATION** e.g. can the person communicate their needs verbally, does the person use Makaton/BSL, can the person understand what is being said to them  |
| **READING/WRITING** e.g. can they read simple sentences/a newspaper/book? Can they write a letter/shopping list/their name?  |
| **INDEPENDENT LIVING SKILLS** **Cooking:**  **Cleaning/laundry:**  **Finances e.g. budgeting, paying bills:**  **Shopping:**  **Using computers/mobile phones:**  **Staying safe/dealing with emergencies:**   |
| **PERSONAL CARE** e.g. washing, dressing, cleaning teeth, using the toilet, shaving etc.  |
| **TRAVEL/MOBILITY** e.g. walking, using maps/following timetables, using public transport  |

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| **Service** | **Contact Person** | **Role** | **Address** | **Contact No.** |
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**OTHER SERVICES INVOLVED WITH THE PERSON e.g. health, social care, day services, school/college, housing, criminal justice service, care providers, voluntary services etc.** |

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| **ETHNICITY****White** **Asian or Asian British**British [ ]  Indian [ ]  Irish [ ]  Pakistani [ ] Greek Cypriot [ ]  Bangladeshi [ ] Turkish Cypriot [ ]  East African Asian [ ] Kurdish [ ]  Any Other Asian Background, (please write in) [ ] Turkish [ ]  Click or tap here to enter text.Any Other White, (please write in) [ ]  Click or tap here to enter text. **Black or Black British****Mixed** Caribbean [ ] Mixed White and Black Caribbean [ ]  African [ ] Mixed White and Black African [ ]  Any Other Black Background, (please write in)Mixed White and Asian [ ]  Click or tap here to enter text.Any other mixed background [ ]  **Chinese or Other Ethnic Group**(please write in) Chinese [ ] Click or tap here to enter text. Other [ ]  |
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| **RELIGION** *specify if known* **Practising** Yes [ ]  No [ ]    |

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| **SEXUALITY** *specify if known*  Prefer not to say [ ] Unable to say [ ]  |

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**Tel: 020 8489 1384 Fax: 020 8489 1327 Email: HLDP@haringey.gov.uk**

**FOR ALL NEW REFERRALS TO THE TEAM PLEASE PROVIDE ADDITIONAL INFORMATION e.g. Statement of Special Educational Needs/Education, Health and Social Care Plan, Psychology or Psychiatry Reports or any other relevant documentation in support of your referral**