BARNSLEY ADULT LEARNING DISABILITIES

SPECIALIST HEALTH SERVICES

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| **REFERRAL FORM**  |

In order that your referral can be processed without delay, please refer to the guidance provided within each section. Please note we cannot fully process your referral until all the information required is provided.

The person must have evidence of a Learning Disability and further assessment may be required, unless the request is for a Learning Disability diagnostic assessment.

**If you struggle to access this form, please contact the Duty Team who can support you.**

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| **SECTION 1: REFERRAL INFORMATION (**Please complete for all referrals) |
| **SECTION 1A: SERVICE CRITERIA** |
| **Does the person have a Learning Disability?**Yes [ ]  No [ ] **Does the person present with an additional health need?** Yes [ ]  No [ ] **Does the person have a Barnsley registered GP?** Yes [ ]  No [ ] **Is the person aged 18 years or over** (we will accept referrals for people aged 17.5 if supporting transition to adulthood) Yes [ ]  No [ ]  |
| **Have attempts been made for the person to access mainstream services prior to this referral?** Yes [ ]  No [ ]  *(please provide further information below)* |
| **SECTION 1B: CAPACITY AND CONSENT** NB: We are unable to accept a referral without consent or a Best Interest Decision. |
| **Does the person have capacity to consent to this referral?** Yes [ ]  No [ ] **If Yes, does the person consent to this referral?** Yes [ ]  No [ ] **If No, is this referral being made in the person’s best interests?** Yes [ ]  No [ ] **Does the person give permission to contact others for further information?** Yes [ ]  No [ ] **If yes, please specify who and preferred contact number:** **Does the person give permission to access their record for additional information to support this referral?** Yes [ ]  No [ ] *(please be aware that without access to these records we will make a decision on the information you provide only. If there is insufficient evidence of a Learning Disability, we may not be able to proceed with the referral).*  |
| **If the referral is made after best interest consideration, who is responsible for making this decision?**  |
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| **Please note:** In all instances where your referral is **URGENT/CRISIS** please contact our Duty Worker on 01226 645237.Referrals that are made for non-urgent services may be placed on a waiting list for up to 18 weeks and prioritised based on risks and service availability.Please be aware that there needs to be a clinical need for a referral to our service for an autism spectrum disorder assessment**.** |

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| **SECTION 2: PERONSAL INFORMATION** (Please complete for all referrals)  |

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| **2A PERSON’S IDENTIFICATION AND CONTACT DETAILS** |
| **NHS No**  |  |
| **First Name:**  |  | **Surname:**  |  |
| **DOB:**  |  | **Gender** |  |
| **Home address:**  |  |
| **Postcode:**  |  | **Landline telephone:**  |  |
| **Mobile telephone:**  |  | **Email:**  |  |
| **GP name:** |  | **GP Surgery:**  |  |
| **GP address:**  |  |
| **Postcode:**  |  | **Phone number:**  |  |
| **2B PROTECTED CHARACTERISTICS**  |
| **Sexual orientation:** |  | **Relationship status:**  |  |
| **Ethnicity:**  |  | **Religion:**  |  |
| **2C COMMUNICATION NEEDS AND REASONABLE ADJUSTMENTS** |
| **Preferred Language**  |  | **Do they require an interpreter?** | Yes [ ]  No [ ]  |
| **Does the person require reasonable adjustments?**  |
| Yes [ ]  No [ ] If yes please specify |
| **Person’s communication needs:** |
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| **2D MEDICATIONS AND ALLERGIES**  |
| **Current medications:** |
| **Please note all known medications:-** *including doses, frequencies or recent changes* |
| **Any known Allergies:** |  |
| **2E CARERS/OTHER RELEVANT PARTIES**  |
| **Main carer name:**  |  |
| **Relationship:**  |  | **Phone Number:**  |  |
| **Address:**  |  |
| **Key relative/friend name (if different from above:**  |  |
| **Relationship:** |  | **Phone Number:**  |  |
| **Address:**  |  |
| **Other professionals involved (name):** |  |
| **Relationship:** |  | **Organisation:**  |  |
| **Telephone number:**  |  | **Other identifier** (If known) |  |
| **Other professionals involved (name):** |  |
| **Relationship:** |  | **Organisation:**  |  |
| **Telephone number:**  |  | **Other identifier** (If known) |  |

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| **SECTION 3: REFERRAL DETAILS** (Please complete for all referrals)  |

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| **Date of referral**:  |  | **Time of referral:**   |  |
| **Name of referrer:** |  | **Relationship:**  |  |
| **Telephone number:**  |  | **Organisation:**  |  |
| **Address:**  |  |
| **Reason for referral:**  | *Please provide as much information as possible so that your referral can be fully understood.*  |
| **Risks**  | *Please provide details of any immediate risk and what has been done to manage this.**Are there any known risks? What are they? What have you done to manage these risks?* *You must specify e.g.: risk to themselves, risk to others, risk to staff/professionals, ongoing safeguarding concerns? Any child safeguarding concerns?* |
| **Desired outcome:**  | *Please describe what support you feel the person needs.*  |
| **SCREENING**  |
| **Please note, as part of our referral process, we need to complete an initial screen. We need to complete this within two weeks of the referral being received otherwise it will be rejected.** **Please indicate who is the best person to complete this screening:**  |
| [ ]  Yourself as the referrer  | [ ]  Family member (please specify) |  |
| [ ]  The person directly | [ ]  Carer (please specify) |  |
| [ ]  Care home  | [ ]  Other (please specify) |  |
| **Please provide a contact number:** Please provide a secondary contact in case we cannot make contactwith the person above:  |  |
| **Additional information:** **Prior to finalising and submitting this form, please check section 5 to find out if there is further information that you need to provide.** |

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| **SECTION 4: PREFERRED METHOD OF CONTACTING PERSON YOU ARE REFERRING** |

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| [ ]  **Contact direct**  | [ ]  **Via carer**  | [ ]  **Via family member/friend** |
| [ ]  **Letter** | [ ]  **Easy read communication** | [ ]  **Mobile**  |
| [ ]  **Landline** | [ ]  **Email**  | [ ]  **Other, please state**  |

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| **Form completed by:**  |  |
| **Job title/role:**  |  |

**Please return this form and all necessary additional information to :-**

**Via email to:** **Barnsley.ld.duty@swyt.nhs.uk**

**Or via post to: Barnsley Adult Learning Disability Community Health Team, 276 Darton Lane, Mapplewell, Barnsley, South Yorkshire, S75 6AJ**

**Tel: 01226 645 237**

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| **SECTION 5: REFERRALS REQUIRING ADDITIONAL INFORMATION (ONLY REFERRALS FOR THE FOLLOWING SHOULD COMPLETE THIS SECTION)** |
| **If your referral is requesting any of the following please tick and complete the relevant section before submitting the referral.** [ ] Learning Disability assessment/diagnosis (please complete section 5A)[ ] Referral for behaviour support (please complete section 5B) [ ] Referral for support with bloods (please complete section 5C, and ensure that you have attached the capacity assessment and the best interests decision) [ ] Referral for Autism assessment (please refer to section 5D)**IF YOUR REFERRAL IS NOT FOR ANY OF THE REASONS ABOVE PLEASE SEND IN YOUR COMPLETED FORM**  |

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| **SECTION 5A- Request for Learning Disability diagnostic assessment**  |
| **Is this person older than 17 years 6 months at the point of referral?** Yes [ ]  No [ ]  |
| **Please provide some evidence to suggest a Learning Disability** 1. **Developmental History e.g. pregnancy, birth, developmental milestones**
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| 1. **Medical history e.g. current diagnoses, serious childhood illness, epilepsy, head trauma**
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| 1. **Educational History e.g. types of schools and college, EHC plan/SEN statement, qualifications achieved**
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| 1. **Current functioning – difficulties relating to social/adaptive functioning e.g. paying bills, accessing employment, attending to personal care/household activities, living situation**
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| **Please provide details of current/previous input (Please attach relevant reports) – e.g. *previous cognitive assessments, EHC plans/SEN statements, support from services*** |
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| **Please be aware the service does not complete assessments as part of parenting assessments or in Child Protection proceedings.****We are also unable to complete assessments with someone 3 months before or 3 months after giving birth.** **Please remember to attach any supporting evidence to the referral form when submitted.**  |

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| **SECTION 5B- Request for behavioural support**  |
| **What is the behaviour?**  |
| [ ]  Physical aggression  | [ ]  Verbal aggression  |
| [ ]  Property destruction [ ]  Self injurious  | [ ]  Socially inappropriate behaviours [ ]  Other (please specify) |
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| **For each box ticked please provide further details on what this behaviour looks like/how it is done.** |
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| **When did the behaviour start?** |
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| **How often are the behaviours occurring and how long do they last? *Please provide as much information as possible.*** |
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| **Have the behaviours led to any serious harm to the person or others? *Please provide as much information as possible.*** |
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| **What interventions have already been tried?** ***Please provide as much information as possible.*** |
|  |
| **Have there been any environmental changes (e.g. moved homes, new people moving in, changes in staff team, changes in family contact, changes in routine) or changes to their physical health (including changes to sleep, appetite, bowels, mood)? *Please provide as much information as possible.*** |
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| **Do they have a behaviour plan or risk assessment in place? If so, has it been reviewed and what changes have been made?** |
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| **What support are you wanting the team to provide? *Please provide as much information as possible.*** |
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| **SECTION 4C- Request for support with bloods (including bloods requiring clinical holds\*)**Please note, we cannot accept referrals for urgent bloods, however we can offer advice if required. For persons without mental capacity, please complete a capacity assessment and any best interests decisions before referring. Please detail reasonable adjustments required/attempted. These documents must be attached to process this referral fully. Email Barnsley.ld.duty@swyt.nhs.uk to request template documents.  |
| **Have any mainstream services been accessed so far?** Yes [ ]  No [ ] **If yes, please detail what was tried and if it was successful?**  |
| **If the referral is a request to support clinical holds, does the person have a care plan/service provider that can facilitate this?** Yes [ ]  No [ ] **If yes, please give details:**  |
| **Have you attached the relevant capacity assessment?** Yes [ ]  No [ ]  |
| **Have you attached the relevant best interests form?** Yes [ ]  No [ ]  |

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| **Section 4d- Referral for an Autism assessment** |
| Please note we can only complete Autism assessments for adults who have a Learning Disability diagnosis. If you have no reason to believe the person has a Learning Disability, please refer to the adult autism team, further information can be found here: <https://www.southwestyorkshire.nhs.uk/services/autism/> Please be aware that there needs to be a health need for a referral to our service for an Autism assessment. **Has this person previously been assessed for Autism?** Yes [ ]  No [ ] **If so, what was the outcome?** |
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| **Is there someone that could provide information about the person’s developmental history? *e.g. social interaction and communication behaviours as a child, developmental milestones?*** |
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| **Reason for referral/presenting problem i.e. what is the clinical need for requesting an assessment for Autism** *(e.g. access to health or social care services, or services in the community, school or employment issues, support with daily functioning), how would the person benefit from being assessed:* |
|  |
| **Please provide examples of the current difficulties the person has in the following areas:** |
| **Social interaction and communication *(e.g. difficulties initiating or maintaining social relationships, wishes to be sociable but fails to make relationships or is not interested in others, says inappropriate things, lacks eye contract, has a literal understanding of things):*** |
|  |
| **Resistance to change or restricted range of interests *(e.g. insists on no change, change can cause severe and overwhelming emotions, can have very strong attachments to particular objects, intense interests):*** |
|  |
| **Stereotypic, rigid or repetitive behaviours *(e.g. these behaviours can be for enjoyment, an attempt to gain or reduce sensory input, to deal with distress; has special routines, over- or under-sensitivity):*** |
|  |
| **Does the person have any current or have they had any historical contact with mental health services?** |
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| **Does the person have a previous diagnosis of a mental health or neurodevelopmental condition *(e.g. health anxiety, depression, ADHD)*** |
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