**CLACKMANNANSHIRE COMMUNITY LEARNING DISABILITY TEAM**

**REFERRAL FORM**

**If you are unsure whether the person you are referring has a diagnosed Learning Disability,**

**please consult the reverse of this form for further guidance**

**If you are referring for a Capacity Assessment, please contact the Team Administrator who will direct you to the Forth Valley Wide Capacity Assessment Pathway**

# If you are unsure whether the person you are referring has a diagnosed Learning Disability, please consult the reverse of this form for further guidance.

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# If you are referring for a Capacity Assessment, please contact the Team Administrator who will direct you to the Forth Valley Wide Capacity Assessment Pathway.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PERSON REFERRED | | | | |
| Full Name: | | | Address: | |
| Prefers to be known as: | | |  | |
| CHI No: | | SW Client No: |  | Postcode: |
| Date of Birth: | | Age: | Tel No’s: | |
| Person’s Communication Method: | | | | |
|  | | |  | |
| PERSON REFERRING | | | | |
| Name: | | | **Address:** | |
| Job Title: | | |  | |
| Organisation/Team: | | |  | **Postcode:** |
| Relationship to Person Referred: | | | **Tel No’s:** | |
|  | | |  | |
| PRIMARY CARER | | | **GENERAL PRACTITIONER** | |
| Name: | | | **Name:** | |
| Relationship to Person Referred: | | | **Practice Name:** | |
| Address: | | | **Address:** | |
|  | | |  | |
|  | Postcode: | |  | **Postcode:** |
| Tel No’s: | | | **Tel No’s:** | |
|  | | |  | |
| Please confirm that either the Person / Guardian / Carer has given permission for this referral to be made: | | | | |
| Does the Person have an allocated Guardian: Yes / No | | | | |
| Please Select Degree of Urgency and Explain Your Reason Below: | | | | |
| Are there ongoing Adult Support and Protection (ASP) Proceedings that we should be aware of: | | | | |
| REASON FOR REFERRAL – define the presenting concerns & the current impact upon the person’s life, what has been tried already, the outcome & why specialist support from LD Services is required. | | | | |
|  | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| KEY AGENCIES INVOLVED (including contact details if possible): | | | | | | | | |
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| **RISKS** | | **LIKELIHOOD OF OCCURRENCE (Please mark with an ‘X’)** | | | | | | |
|  | | **Unlikely** | | | **Possible** | **Probable** | | **Unknown** |
| **Actual Violence** | |  | | |  |  | |  |
| **Aggression** | |  | | |  |  | |  |
| **Verbal Abuse** | |  | | |  |  | |  |
| **Sexual Innuendo / Comment / Inappropriate Touching** | |  | | |  |  | |  |
| **Non-Prescribed Drug Use** | |  | | |  |  | |  |
| **Excess Use of Alcohol** | |  | | |  |  | |  |
| **Hostile Neighbours / Other Occupants** | |  | | |  |  | |  |
| **Aggressive Animals** | |  | | |  |  | |  |
| **Poorly Lit Environment** | |  | | |  |  | |  |
| **Car Parking Difficulties** | |  | | |  |  | |  |
| **Other:** | |  | | |  |  | |  |
|  |  | | | | | | | |
| Signature of Referrer: | Date of Referral: | | | | | | | |
|  |  | | | | | | | |
| **PLEASE RETURN COMPLETED FORM TO:** | **FOR SERVICE USE ONLY** | | | | | | | |
| **Email:** [**fv.cldt@nhs.scot**](mailto:fv.cldt@nhs.scot) | **Date Received:** | | |  | | | | |
| **If Telephone Referral Please Sign:** | | | | | | | |
| **New Referral: 🞎** | | | | | | **Re-Referral: 🞎** | |
| **X-Referral: 🞎** | | **From:** | | | | **To:** | |

# Additional Guidance for Referrers

# This form can be completed to refer people with a diagnosed Learning Disability who reside in the Stirling/Clackmannanshire areas to any of the following services: Art Therapy, Dietetics, Music Therapy, Nursing, Occupational Therapy, Physiotherapy, Psychiatry, Psychology, Social Work and Speech & Language Therapy. If the person is capable of accessing mainstream services however, then they should do so. Examples of barriers to individuals accessing mainstream services could include (but are not limited to) having special health care or communication needs, challenging behaviours or epilepsy management issues.

# If you are referring this person for assessment because you suspect that they may have a Learning Disability then please detail in the ‘Reason for Referral’ section overleaf, what led you to suspect this. Please remember to confirm overleaf that you have sought permission (from the individual or their Guardian) to refer this individual for assessment. Consent for assessment will be reviewed at the first appointment.

# We accept referrals for adults (age 16 and over) with a learning disability. A learning disability is a significant life-long condition, with the following facets:

# A significant impairment of intellectual functioning (e.g. the ability to understand new or complex information or to learn new skills).

# A significant impairment of adaptive behaviour (i.e. the ability to cope independently – social, conceptual and practical skills).

# Onset of these issues before adulthood (age 18).

# This definition encompasses people with a broad range of disabilities. The presence of all three criteria have to be present for an individual to receive a diagnosis of a learning disability.

# The Learning Disability Service will NOT accept referrals for:

# Individuals who only have specific learning difficulties such as dyslexia, dyscalculia or dyspraxia.

# Individuals who have acquired cognitive impairments after the age of 18, such as people with acquired head injuries or cognitive difficulties resulting from long term substance misuse.

# Individuals with an Autistic Spectrum Disorder (including Asperger’s Syndrome) alone.