##

**ADULT NEURODEVELOPMENTAL SERVICES REFERRAL FORM**

**Section 1**

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| **QUESTION** | **YES** |  | **NO** |
| 1. Has the person ever been seen by a learning disability service before?
2. If yes, what were they seen for?
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|  |  |

**If YES to Question 1 please go to section 3. If NO please complete section 2.**

**Section 2**

**Please read and complete this section before going to Section 3.**

Learning disability only affects around 2% of the population and often gets confused with other conditions. It is not ADHD, brain injury (occurring post 18 years), dyscalculia, dyslexia, dyspraxia, autistic spectrum disorder (including Asperger syndrome), or a mental health issue.

The terms learning difficulty and learning disability get used interchangeably, but they are very different.

A **Learning difficulty** is any learning or emotional problem that affects, or substantially affects, a person’s ability to learn, get along with others and follow convention.

A **Learning disability** is a significant, lifelong condition that starts before adulthood, affects development and leads to help being required to:

* Understand information
* Learn skills
* Cope independently

The NHS definition of a Learning Disability implies an IQ below 70.

**To ensure you are making a referral to the right service please answer the questions over leaf.**

**Please tick**

|  |  |  |  |
| --- | --- | --- | --- |
| **QUESTION** | **YES** |  | **NO** |
| 1. Has the person attended mainstream school (without support)?
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| 1. Has the person gained any nationally recognised qualifications (e.g. GCSEs, A levels, or the equivalent)?
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|  |
| 1. Have they ever had paid employment without support for longer than 1 month?
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| 1. Do they have a FULL driving licence?
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| 1. Have they made a complex purchase, such as buying a house or car on finance?
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| 1. Have they ever had an IQ test where they scored above 70?
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**If YES has been ticked for any of the above questions it is highly unlikely that the person has a learning disability, and Community Support Team (CST) learning disabilities is not the appropriate service.**

**If you still suspect a Learning Disability please ring the team to discuss prior to making a referral.**

**If they did NOT get any YES answers this does not mean that the person has a learning disability, but further assessment may be indicated.**

**Please complete Section 3.**

**Section 3**

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| --- | --- | --- | --- | --- | --- |
| **Name:** | **Male** |  | **Female** |  | **D.O.B.**  \_ \_ / \_ \_ / \_ \_ \_ \_  |
| **Address:** | **NHS No:** \_ \_ \_ / \_ \_ \_ / \_ \_ \_ \_  |
|  | **Ethnicity / Culture:**  |
|  | **Marital Status:** |
| **Post Code: Tel No.:** | **Religion:** |
| **Email Address:**  |  |
| **Next of Kin:** | **Main Carer(s):** | **GP:** |
| **Address:****Email Address:** **Post Code:****Tel No:** | **Address:****Email Address:** **Post Code:****Tel No:** | **Address:****Post Code:** **Tel No:** |
| **Other Professionals/Agencies Involved:** |
| Role/Service | Report/Document Available | Current Involvement | Name & Contact Details |
|  |  |  |  |
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**Referral Information:**

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| --- | --- | --- | --- |
| **Has the person agreed to this referral?**  | **YES** |  | **NO** |
| If not, why not? (e.g. because they do not understand)   |  |  |
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| **If appropriate, has the main carer(s) been made aware of the referral?** | **YES** |  | **NO** |
| If not, why not?  |  |  |
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| **Reason for Referral:** (Please state what has led you to make this referral, how long it has been an issue and what you think the person needs from the team. Give as much detail as possible, including information about changes in behaviour, mood, mental health, physical health, as applicable).  |
| **Please describe the impact of the difficulties (e.g. distress, frustration):** |

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| --- |
| **Are there any risk issues, including face to face working ? (if you are not aware of any state ‘None known’)****Please share any information that will help us manage these risks:** |

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| **What is the best way to get in touch with the person?** |

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| **Please attach any additional information:****(If this is part of the transition into adult services, please attach previous assessments/reports/plans)**  |
| **Referrer Name:****Relationship to Service User:** | **Referrer work or office address & tel No for correspondence (unless family carer/family member):** |
| **Signature:** | **Date:** |

**Please return this completed form to Adult Neurodevelopmental Referrals Team at either of the below addresses or via email.**

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| **Adult Neurodevelopmental Services Referrals Team**2nd Floor, St Andrews House, 201 London Road, Derby. DE1 2SXTel: 01332 268470 – Extension 32488Rivermead, Unit 1, Goods Road, Belper, Derbyshire DE56 1UUTel: 01773 882501**All referrals can be emailed to:** **dhcft.ansadmin@nhs.net** |