Fife Health & Social Care Partnership
Supporting the people of Fife together

COMMUNITY LEARNING DISABILITIES TEAM
CLIENT REFERRAL FORM

Section A

Surname:	Main Carer:
Forename:	Relationship:
Male/Female: Date of Birth:	Address:
CHI Number:	
Address:	Post Code:
	Tel No:
Post Code:	Guardian Details (if applicable):
Tel No:	Type of Guardianship:

LIVING SITUATION: Lives independently ☐ Supported Accom ☐ With Carer ☐
&
TYPE OF RESIDENCE: Mainstream housing ☐ Sheltered housing ☐
NHS facility ☐ Registered care home ☐ Mobile accommodation ☐ Homeless ☐
Other ☐ please state:

REFERRED BY *(Name & Position)*	
Address:	Tel:
Email Address:	Date:

Is the client able to agree to the referral? **YES** ☐ **NO** ☐
Has the client agreed to the referral? **YES** ☐ **NO** ☐
Has referral been agreed with Guardian / relative? **YES** ☐ **NO** ☐
Has the GP been notified of the referral? **YES** ☐ **NO** ☐
Does the person require an interpreter or access to other communication supports in order to access this service? (Please detail)

GENERAL PRACTITIONER ***(details of GP must be completed)***

Doctor	Surgery	Telephone Number

OTHER PROFESSIONALS, AGENCIES & SUPPORTS (only detail those not already mentioned above)

Name/Relationship	Address & email	Telephone Number

Is the Person already known to the Adult Learning Disability Service? YES ☐ NO ☐
If this is not in Fife, please specify where:
If **NO** now go to **Section B** or If **YES** now go to **Section C**

Section B - This section will help to establish if this is the appropriate specialist service for the person	**Yes**	**No**
a) Has a diagnosis of learning disability already been made by a health professional?	☐	☐
b) Does the person have reduced ability to understand new or complex information?	☐	☐
c) Does the person have difficulty coping independently with tasks of daily living?	☐	☐
d) Has the person experienced a significant head injury, accident or illness resulting in damage to the brain, post 18 years of age?	☐	☐
e) Does the person have a diagnosed mental health problem	☐	☐
f) Is the person accessing mental health services?	☐	☐
g) Does the person have a physical disability?	☐	☐
Please use this space to expand on any answers above:		
Does the person display any other difficulties that lead you to believe they have a Learning Disability? (e.g. educational history, employment history, a specific condition associated with having a learning disability). Please give details:		

Section C

Is this a transition referral from Child to Adult services? YES ☐ NO☐

Is this referral for a Learning Disability Assessment? YES ☐ NO☐

Please answer these questions as fully as you can.
Please give a background history for the person (include medical, social, family situation, environmental and significant life events) **What has changed recently that has prompted you to make this referral now?** **NB- Please note here if there is something specific you think the team could do which would help** **What impact have these changes had on the client's life?**

What has been tried already and what difference did it make?

Section D - Risk	Yes	No
a) Is the person a risk to themselves? (e.g. self harm, suicidal ideation, substance misuse, falls)	☐	☐
b) Does the person pose a known risk to other people including staff and professionals?	☐	☐
c) Are there any other risk factors our service should be aware of? (pets, other household residents, environmental etc)	☐	☐
NB - If you have answered yes to any of the above questions someone will contact you via telephone to get further details		

Please return to: Referral Coordinator
Community Learning Disabilities Service
Lynebank Hospital
Halbeath Road
DUNFERMLINE
KYI I 4UW
Email: fife-uhb.LDreferrals@nhs.net
Tel No: (01383) 565230

Date referral received: ………………….Date referral discussed by CLDT:………………