

# LAMBETH TEAM FOR ADULTS WITH LEARNING DISABILITIES - REFERRAL FORM

(Please complete ALL parts of this form and return to: gst-tr.AWLDHealthTeam@nhs.net)

Date of referral

First name Last name D.O.B

Gender

[ ]  Male [ ]  Female

NHS Number

Address Postcode

Client telephone number Contact name and number

Name of referrer

Relationship of referrer to

client Referrer email

Referrer address Telephone number

# Services required (please tick as many as you need)

[ ]  Community Nursing

[ ]  Speech & Language Therapy (communication) [ ]  Eating & Drinking \*

[ ]  Physiotherapy

[ ]  Occupational Therapy

\*Please note, this is for dysphagia, choking, and swallowing difficulties only

Language(s) spoken by service user and principal carer(s)

Is an interpreter required? [ ] Yes [ ]  No

Other professionals currently working with the service user (name, profession and contact details):

Other professionals who have worked with the service user in the past:

Name, address and telephone number of GP:

Please give ethnicity of service user and who determined this:

Hospital inpatient? If yes, please give details

# Is the person known to the Team? If no, please fill in boxed section below:

Please state principal carers/agency support service user:

Evidence of learning disability (please attach any relevant assessments, reports and letters for background information):

History of support given to service user (school history, details of any diagnosis, placement history, current situation if not already included:

**Reason for referral:** (Is there any change in the client’s behaviour?)

Please note: It is important to mention any known risks to service user or others.

Has the service user consented to this referral?

[ ]  Yes [ ]  No

# If consent has *not* been given, please explain why

Please return the form to:

# Lambeth Team for Adults with Learning Disabilities

121 Townley Road East Dulwich London SE22 8SW

gst-tr.AWLDHealthTeam@nhs.net

Tel: **0203 049 7518**

Date referral received Date taken to MDT

 