

# LEWISHAM TEAM FOR ADULTS WITH LEARNING DISABILITIES - REFERRAL FORM

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

Audiology

\*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:

# Lewisham Team for Adults with Learning Disabilities

1st Floor, Old Town Hall

Catford

London SE6 4RU

[gst-tr.AWLDHealthTeam@nhs.net](mailto:gst-tr.AWLDHealthTeam@nhs.net)

Tel: **0203 989 0550**

Date referral received Date taken to MDT

