

LEWISHAM 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

NHS Number:

Male

Female

Address

Post code

Telephone Number

Name of referrer

Relationship of referrer to client

Referrer Address

Telephone Number

Services required (please tick as many as you need)

Community Nursing

Physiotherapy

Speech & Language Therapy (communication)

Occupational Therapy

Eating & Drinking *

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

19-21 Brownhill Road, Catford

London

SE6 2HG

gst-tr.AWLDHealthTeam@nhs.net

Tel: **0203 228 9620** Fax: **0203 228 9601**

Date referral received

Date taken to MDT

