

Adult Learning Disabilities Service

Referral to Community Team (WHITE FORM)

SOUTH NORTH

Please refer to Guidance Notes



1. CLIENT DETAILS

Surname			Address	
Forename				
Known as				
Date of Birth				
Chi No.				
PIMS No.			Postcode	
Title		M / F	Tel No.	

2. REFERRER DETAILS

Is Client Aware of Referral? Yes No If not, why: _____

Referrer			Address	
Designation				
Relationship				
Agency				
Email Address				
Fax No.			Postcode	
			Tel No.	

3. REFERRAL DETAILS

(Please tick appropriate box and give details)

- Autistic Spectrum Disorder
- Challenging Behaviour Issue
- Complex Physical Issue
- Epilepsy Management
- Mental Health Issue
- Forensic/Offending Issue
- Transition Issues
- Other (Please specify)

Presenting problems or issues

Risk Identifier

Please identify any presenting risks that may arise from this referral from the client, environment or other:

4. OTHER AGENCIES INVOLVED

	Contact Name / Address / Tel No.	Details
Social Work <input type="checkbox"/>		
Housing Dept. <input type="checkbox"/>		
Education <input type="checkbox"/>		
Other (Please Specify) <input type="checkbox"/>		

5. CARE MANAGER DETAILS		
Name	<input type="text"/>	Address
Tel No.	<input type="text"/>	
Email Address	<input type="text"/>	Postcode

6. CARER DETAILS	--	MAIN CARER	OTHER CARER
Name		<input type="text"/>	<input type="text"/>
Relationship Or Organisation Address		<input type="text"/>	<input type="text"/>
Postcode		<input type="text"/>	<input type="text"/>
Tel No.		<input type="text"/>	<input type="text"/>

7. GP DETAILS		
Name	<input type="text"/>	Address
Practice Code	<input type="text"/>	
Tel No.	<input type="text"/>	Postcode

8. NEXT OF KIN DETAILS		
Name	<input type="text"/>	Address
Relationship	<input type="text"/>	
Tel No.	<input type="text"/>	Postcode

9. OTHER INFORMATION

10. Previous involvement with Community Learning Disability Team? Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Professions involved and reason:

Referrer Signature: _____ **Date:** _____

Please forward completed form to:
Service Development Manager
Kirklands Hospital
Fallside Road
Bothwell G71 8BB

The Service Development Manager will record these details
in the database and distribute the information to all
relevant departments for their action

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Official Use only: Referral Form Received ___ / ___ / ___

Referral Processed by

ROUTINE URGENT

Signature _____