



REFERRAL FORM

COMMUNITY LEARNING DISABILITIES & AUTISM NURSING SERVICE

Referral for Learning Disabilities/Autism Nursing Service (Child or Adult)

REFERRED BY:

TELEPHONE:

EMAIL:

DATE OF REFERRAL:

Are there any concerns/safety issues regarding lone worker status and home visits?

YFS	NO	
ILJ		

If yes, please state:

NAME OF INDIVIDUAL REQUIRING SERVICE:

DOB/CHI:

ADDRESS:

POSTCODE:

TELEPHONE:

GP NAME:

ADDRESS:

POSTCODE:

CONTACT TELEPHONE NUMBER:

LD/ASD Referral Form (V2)





CONSENT

Has the person verbally/physically agreed to the referral?

If under 16 has the person/parent verbally consented to this referral?

YES	NO
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If over 16 and unable to give consent; does the person have a welfare guardian?

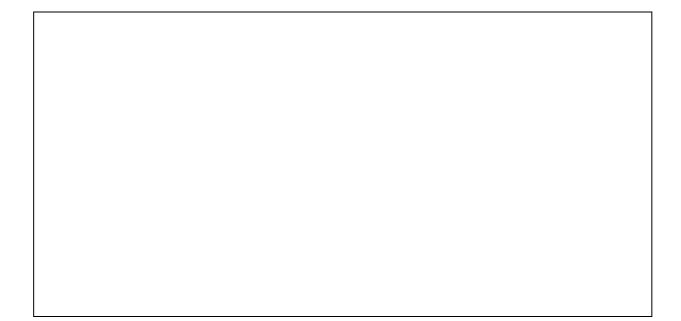
YES	NO	

Has consent to share information with others for the benefit of the person been given?

YES	NO	
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Is the person's Next of Kin aware of this referral?

Does the person have additional health needs requiring specialist input from the Learning Disability Nurse, for example: Mental Health; Behaviour management; Communication; Health promotion/education relating to an identified health need such as Epilepsy etc.







MEDICATION

Medication Name	Dose	Frequency	Date Started

Others involved in supporting the person, i.e. Health, Social Work, Education:

NAME	INVOLVEMENT	CONTACT INFORMATION

Reason for referral: Please state clearly any identified need, the effect on the person and the situation.





To prioritise referrals, please complete the following by ticking the boxes as appropriate:

The person's current day/residential placement is at risk of breaking down

YES	NO	
YES	NO	

There is risk of self-harm to the person and/or others

YES	NO	

There is risk of neglect and/or abuse

YES		NO
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There are significant changes to the person's behaviour

YES NO

There are significant changes in the person's health status

YES	NO
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PLEASE BE ASSURED ALL INFORMATION WILL BE TREATED CONFIDENTIALLY

Please return the completed form to:

Gary Docherty, Consultant Learning Disability Nurse

Independent Living Centre Gremista Lerwick ZE1 0XY

Telephone: 07385425036 Email: <u>gary.docherty@nhs.scot</u>

ADMIN USE ONLY

Date Received	
Date of Contact	
CLDN SIGNATURE	

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