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| **Scottish Borders****Learning Disability Service** |  |

# REFERRAL FORM

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| **CHI:** FIRST NAME: **SURNAME:** PREFERRED NAME: **GENDER:** **D.O.B:** **ADDRESS:** **TEL NO:**

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 | NEXT OF KIN:  TEL NO:  |
| G.P: Tel:  | **TEL NO:**  |
| REFERRED BY: DATE OF REFERRAL: TITLE/STATUS: ORGANISATION + ADDRESS:  |
| **REASON FOR REFERRAL**, (including risk factors and person referred to if known) |
| **RELEVANT MEDICAL HISTORY (**eg, physical and psychiatric illness, medication etc) |

**If referral is for Autism Diagnostic Service – please complete**

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| **SCREENING TOOL SCORE** – please see attached screening tool **Score ……..** |

**If referral is for Forensic Service -** Forensic information must be completed

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| **INVOLVED LD PROFESSIONALS** – for admin use onlyHEALTHSOCIAL WORKOUTCOME (including if person fits the criteria for LD Service Y/N ) |

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| HAS GP BEEN CONSULTED?  HAS REFERRAL BEEN DISCUSSED WITH MEMBER OF LEARNING DISABILITY TEAM?  HAS CONSENT BEEN GIVEN FOR THIS REFERRAL?  *If no or unable please give details*HAS CONSENT BEEN GIVEN TO SHARE INFORMATION? *If no or unable please give details***IF REFERRAL FOR AUTISM – HAS REFERRAL BEEN DISCUSSED WITH THE FAMILY? YES / NO** |

**Please now E-mail form to –** **lds.admintasks@borders.scot.nhs.uk** **or** **sw.ldt@scotborders.gov.uk**

**Or send hard copy to -**

**Scottish Borders Learning Disability Service**

**Church Street**

**Earlston**

**TD4 6HR**

**Tel: 01896 840200 Fax: 01896 840222**