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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:**   |  |  | | --- | --- | |  |  | | | 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 only  HEALTH  SOCIAL WORK  OUTCOME (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**](mailto:lds.admintasks@borders.scot.nhs.uk) **or** [**sw.ldt@scotborders.gov.uk**](mailto:sw.ldt@scotborders.gov.uk)

**Or send hard copy to – Scottish Borders Learning Disability Service, NHS Floor, Extension Building, Council Headquarters, Newtown St Boswells, Melrose TD6 0SA**

**Telephone: 01835 340610**