**REFERRAL FORM**

**Client Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name**: | | **Surname**: | |
| **NHS No.**: | | **Marital Status:** | |
| **DOB**: | | **Religion**: | |
| **Gender** : | | **Preferred Language**: | |
| **Ethnicity**: | |  | |
| **Address:**  **Post Code:**  **Landline Tel:**  **Mobile Number:**  **Email Address:** | | **GP Name:**  **Surgery Name:**  **GP Address:**  **Postcode:**  **Phone Number:** | |
| **Clients Communication Needs:** | | | |
| **Clients Current Medications:** | | | |
| **Any known Allergies:** | | | |
| **Main Carer Name: Relationship:**  **Telephone Number:**  **Address:** | | | |
| **Key Relative/Friend Name: Relationship:**  (if different from above)  **Telephone Number:**  **Address:** | | | |
| **Other Professionals:**  **Relationship:**  **Organisation:**  **Telephone Number:**  **Address:**  **Other Identifier** (if known)**:** |  | |  |

**Referral Details:**

|  |  |
| --- | --- |
| **Date of Referral**: | **Time of Referral:** |
| **Name of Referrer:**  **Relationship:**  **Telephone Number:** **Organisation:**  **Address:** | |
| **Reason for Referral:** | |
| **Desired outcome:** | |
| **Does Service User have capacity to consent to this referral?**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **YES** |  | **NO** |  |  |  |  | | |
| **Does Service User consent to this referral?**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **YES** |  | **NO** |  |  |  |  | | |
| **If referral made after best interest consideration who is responsible for making this decision?** | |
| **Preferred method of contacting Service User:**   |  |  |  |  | | --- | --- | --- | --- | |  | **Letter** |  | **via Carer** | |  |  |  |  | |  | **Easy Read Communication** |  | **via Family Member / Friend** | |  |  |  |  | |  | **Mobile Phone** |  | **Other** | |  |  |  |  | |  | **Landline** |  |  | |  |  | (Please state) | | |  | **Email** |  | | | |
| **Form Completed By**: | |
| **Job Title / Role:** | |

**Please return this form to :- Via email to:** [**Kirklees.LD.Duty@swyt.nhs.uk**](mailto:Kirklees.LD.Duty@swyt.nhs.uk)

**Or via post to: Kirklees Learning Disability Community Health Team**

**The Resource Unit, Cullingworth Street, DEWSBURY, WF13 4AN**

**Tel : 01924 316714**

**For further information and in all instances where your referral is URGENT please contact our Duty Worker as above.**