**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**

**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.**