Fife Health & Social Care Partnership
Supporting the people of Fife together

ADULT COMMUNITY LEARNING DISABILITIES TEAM
CLIENT REFERRAL FORM

SECTION A

Surname:	Main Carer:
Forename:	Relationship:
Male/Female:	Address:
Date of Birth:	
CHI Number:	Post Code:
Address:	Tel No:
	Guardian Details (if applicable):
Post Code:	Type of Guardianship:
Tel No:	

LIVING SITUATION:	Lives independently ☐	Supported Accom ☐	With Carer ☐
TYPE OF RESIDENCE:	Mainstream housing ☐ Registered care home ☐ Other ☐ please state:	Sheltered housing ☐ Mobile accommodation ☐	NHS facility ☐ Homeless ☐

Referrer's Name:	
Referrer's Position:	
Address:	Tel: 35259
Email Address:	Date:

Is the client able to agree to the referral?	**YES** ☐	**NO** ☐
Has the client agreed to the referral?	**YES** ☐	**NO** ☐
Has referral been agreed with Guardian / relative?	**YES** ☐	**NO** ☐
Has the GP been notified of the referral?	**YES** ☐	**NO** ☐

Does the person require an interpreter or access to other communication supports in order to access this service? (*Please detail*):

GENERAL PRACTITIONER *(details of GP must be completed)*

Doctor	Surgery	Telephone Number

OTHER PROFESSIONALS, AGENCIES & SUPPORTS (*only detail those not already mentioned above*)

Name/Relationship	Address & email	Telephone Number

Is the Person already known to the Adult Learning Disability Service? **YES** ☒ **NO** ☐

If this is not in Fife, please specify where:

If **NO** - go to **SECTION B** If **YES -** go to **SECTION C**

SECTION B

This section will help to establish if this is the appropriate specialist service for the person	**Yes**	**No**
a) Is this a transition referral from Child to Adult services?	☐	☐
b) Has a diagnosis of learning disability already been made by a health professional?	☐	☐
If you have answered "No" to question above: Is this referral for a Learning Disability Assessment?	☐	☐
c) Does the person have reduced ability to understand new or complex information?	☐	☐
d) Does the person have difficulty coping independently with tasks of daily living?	☐	☐
e) Has the person experienced a significant head injury, accident or illness resulting in damage to the brain, post 18 years of age?	☐	☐
f) Does the person have a diagnosed mental health problem	☐	☐
g) Is the person accessing mental health services?	☐	☐
h) Does the person have a physical disability?	☐	☐
Please use this space to expand on any answers above:		
Does the person display any other difficulties that lead you to believe they have a Learning Disability? (e.g. educational history, employment history, a specific condition associated with having a learning disability). Please give details:		

SECTION C

Please answer these questions as fully as you can.

Is this referral for a Capacity Assessment? YES ☐ NO ☐

Does this referral relate to an AWI matter? YES ☐ NO ☐

Please give a background history for the person ***(include medical, social, family situation, environmental and significant life events)***

What has changed recently that has prompted you to make this referral now? ***NB- Please note here if there is something specific you think the team could do which would help***
What impact have these changes had on the client's life?
What has been tried already and what difference did it make?

SECTION D

Risk	**Yes**	**No**
a) Is the person a risk to themselves? (e.g. self harm, suicidal ideation, substance misuse, falls)	☐	☐
b) Does the person pose a known risk to other people including staff and professionals?	☐	☐
c) Are there any other risk factors our service should be aware of? (pets, other household residents, environmental etc)	☐	☐
NB: If you have answered yes to any of the above questions someone will contact you via telephone to get further details.		

PLEASE RETURN TO: Referral Coordinator
Community Learning Disabilities Service
Lynebank Hospital
Halbeath Road
DUNFERMLINE
KY11 4UW
Email: ***Fife.LDReferrals@nhs.scot***
Tel No. 01383 565230 (x35230)