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**CLDS Referral form**

1. Please complete the following referral form giving as much detail as possible.
2. If there are sections that are not completed, the form may be returned to you.
3. If the service does not feel that there is clear evidence in the referral form to support a possible diagnosis of a global learning disability, then we will not offer an assessment for the person referred.
4. **Please note that a person must have a Camden GP to be considered for both health and social care from CLDS.** If they live in Camden but have a GP in a different borough, please refer to that borough’s learning disability service to determine their eligibility for learning disabilities services. Any identified social care needs will be the responsibility of the London Borough of Camden.
5. Our postal address is:

CLDS, Camden Town Hall, Judd Street, London WC1H 9JE

telephone 020 7974 3737 or 020 7974 3761 duty

1. Our CLDS email is - [CLDS.duty@nhs.net](mailto:CLDS.duty@nhs.net)
2. If you are using a non NHS email address and want to refer someone, please be aware that the email will not be secure. You may want to do a telephone referral or post a paper copy instead.
3. GDPR (General Data Protection Regulation) - you can view Camden’s privacy notice here: <https://camdencarechoices.camden.gov.uk/information-and-advice/care-options/assessment-of-your-care-and-support-needs/information-that-we-collect-about-you/>. It explains how and why we use any information we collect about you, how we may share your information, how long we keep your information and your rights.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title | | Mr  Mrs  Ms  Miss | | | | Female  Male  Other | | |
| Name | | First name | | | | Family name | | |
| Date of birth | | day month year | | | | | | |
| Address | | | | | | Phone number | | |
|  | | | | | | Mobile | | |
|  | | | | | | C:\Rich\images & symbols\image store\NHS number.pngNHS No | | |
| Postcode | | | | | |
|  | | | | | | | | |
| What is the best way to contact this person?  Phone person  Phone carer (please give details)  Text person/carer  Email (please give details)  ...............................@.....................................  First language:  Is an interpreter required? **Yes  No** | | | | | | | | |
|  | | | | | | | | |
| Type of accommodation  Residential care  Hospital  Nursing home | | | Living with family  Living alone  Supported living | | | Lives with carer/foster carer  Adult family placement  Privately rented/owned | | |
|  | | | | | | | | |
| How long has the person lived in Camden? | | | | | | | | |
|  | | | | | | | | |
| Next of kin/significant other - | | | | | | | | |
| Relationship to client:  Address: | | | | | | | | |
| Phone number Mobile | | | | | | | | |
|  | | | | | | | | |
| Camden GP name - | | | | | | | | |
| Address: | | | | | | | | |
| Phone number Mobile | | | | | | | | |
|  | | | | | | | | |
| Has the person received a Learning Disability service from any other team previously?  **Yes  (please provide details)**  ...............................................................................................................................................  **No**  *If Yes, please provide details (other local authority or similar service in another country)* | | | | | | | | |
|  | | | | | | | | |
| Is the person a British National or UK Citizen?  **Yes  No  (please provide details of immigration status)**  ...............................................................................................................................................  *This does not mean we will not assess you but could affect the services you are entitled to* | | | | | | | | |
|  | | | | | | | | |
| Has the person consented to this referral?  **Yes  No  (please provide details of why\*)**  ...............................................................................................................................................  Does the person you are referring see her/himself as having a learning disability?  **Yes  No**  \**By law, the Mental Capacity Act (2005) says we have to make sure our service users consent to this referral. If a person lacks capacity to consent, a best interests decision must be made on the person’s behalf. Please follow the Mental Capacity Act guidance.* | | | | | | | | |
|  | | | | | | | | |
| Does the person have parental responsibilities for any children?  **Yes  (please provide details including name(s), date(s) of birth and place of**  **residence**  ...............................................................................................................................................  **No** | | | | | | | | |
|  | | | | | | | | |
| Has the person had a brain injury which has caused cognitive impairment (when a person has trouble remembering, learning new things, concentrating or making decisions that affect their everyday life)?  **Yes  (please provide details and age when the brain injury happened)**  ...............................................................................................................................................  **No** | | | | | | | | |
| Did the person attend any special schools or have additional support in mainstream school? If so, did they have a Statement of Special Educational Needs (SEN) or an Education, Health and Care plan (EHCP)?  **Yes  (please provide details and send a copy of any SEN statement or EHCP if**  **available)**  ...............................................................................................................................................  **No**  Did the person take any exams?  **Yes  (please provide details of type of exam, level of qualification, grade and**  **subject?)**  ...............................................................................................................................................  ...............................................................................................................................................  **No** | | | | | | | | |
|  | | | | | | | | |
| Has the person ever had a job (paid or voluntary)?  **Yes  (please provide details of job role, reason for leaving, did they have extra**  **support to do the job )**  ...............................................................................................................................................  ...............................................................................................................................................  **No** | | | | | | | | |
|  | | | | | | | | |
| Is the person in receipt of any benefits?  **Yes  (please provide details)**  ...............................................................................................................................................  ...............................................................................................................................................  *If Yes, please provide details and rates (e.g. DLA, ESA, JSA, PIP)*  **No** | | | | | | | | |
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| **The following questions will help us to decide if the person meets eligibility criteria for our service. Please answer all the following questions or your referral may be returned.**  Is there a diagnosis of a learning disability (mental handicap, global developmental delay, intellectual disability, mental retardation etc.) in any notes?  **Yes  (if Yes, please provide details e.g. Downs Syndrome, Retts Syndrome**  **diagnosed by GP, consultant and date of IQ assessed as below 70 and**  **provide reports)**  ...............................................................................................................................................  ...............................................................................................................................................  **No**  Did this start before the age of 18? **Yes  No**  How does their Learning Disability impact on their life?  ................................................................................................................................................................................................................................................................................................................................................................................................................................................  Please provide any supporting evidence and attach relevant reports  ................................................................................................................................................................................................................................................................................................................................................................................................................................................ | | | | | | | | |
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| **Reason for referral**  (Please provide clear information about why this referral is being made, e.g. concerns about behaviour, contact with Mental Health services, risks or support needs etc.. Please be as specific as possible and give examples and reasons why the support is required)    In your view is this person vulnerable? **Yes  No**  **Activities of daily living**  Can they maintain a clean and tidy appearance by themselves? **Yes  No**  Do they need help to use the toilet or for other personal care? **Yes  No**  Do they need help to feed themselves appropriately? **Yes  No**  Can they travel independently **Yes  No**  **Understanding communication**    Can they follow simple instructions without help **Yes  No**  Can they follow long instructions without help? **Yes  No**  Can they understand abstract/complex information? **Yes  No**    Can they read and/or write? **Yes  No**  Any other information about their communication skills?  ................................................................................................................................................................................................................................................................................................................................................................................................................................................ | | | | | | | | |
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| **Safeguarding / risk**  Is person at risk of harm to self? **Yes  No**  Is person at risk of harm to others? **Yes  No**  Is person at risk of neglect/self-neglect? **Yes  No**  Does the person have a risk assessment? **Yes  No**  Past / present involvement with the Criminal Justice System? **Yes  No**  If Yes to any of the above, please provide details and/or reports | | | | | | | | |
|  | | | | | | | | |
| **Other people involved with this person and their contact number** | | | | | | | | |
|  | Name | | | Department | | | Role | Contact No |
| Mental Health services |  | | |  | | |  |  |
| Children’s services |  | | |  | | |  |  |
| Housing |  | | |  | | |  |  |
| Specialist Consultant |  | | |  | | |  |  |
| District Nurses |  | | |  | | |  |  |
| Health services |  | | |  | | |  |  |
| Other |  | | |  | | |  |  |
|  | | | | | | | | |
| **About you** | | | | | | | | |
| Name | | | | | Address | | | |
| Phone number | | | | | Postcode | | | |
| Email address | | | | |  | | | |
| Your role | | | | | | | | |
| Best times to contact you (if needed) | | | | | | | | |
| Your name (please print) | | | | | Your signature | | | |
| Date | | | | | | | | |
|  | | | | | | | | |
| Our postal address:  Our phone numbers: | | | | | **CLDS**  **Camden Town Hall**  **Judd Street**  **London WC1H 9JE**  **020 7974 3737**  **020 7974 3761 duty** | | | |
| CLDS email: | | | | | [CLDS.duty@nhs.net](mailto:CLDS.duty@nhs.net) | | | |
| If you are using a non NHS email address and want to refer someone, please be aware that the email will not be secure. You may want to do a telephone referral or post a paper copy. | | | | | | | | |