Manchester Local Care Organisation

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External Referral Form
Health Staff in the Community Learning Disability Teams

Form for people known to have a learning disability

1. Person's Details	2. Referrer's Details
Name: Address: Postcode: Telephone Number: Accommodation type: …… DOB: Gender: Ethnicity: NHS number:	Name of referrer: Role/ Organisation: Address: Postcode: Telephone Number: Email address: Relationship to person: Has the person agreed to this referral? Yes ☐ No ☐ If not why not: ……..
3. Reason for referral (If necessary please continue on an additional sheet and attach)	

If you feel this referral is urgent, please outline your reason:

Which profession(s) do you think can assist this person:
Community Learning Disability Nursing ☐
Occupational Therapy ☐
Speech and Language Therapy ☐
Psychology and Behavioural Support ☐
Psychiatry ☐
Physiotherapy ☐
Don't know ☐

Have you discussed this referral with anyone in the Community Learning Disability Team?

4. Person's communication and information needs- this is a mandatory field to comply with the national accessible information standard.

Please put 'don't know' if you do not have this information.

Language(s) understood: …….

Languages spoken: ……..…….

Language(s) read: ……

Person's hearing: …….

Person's vision: …….

Interpreter needed for person? Interpreter needed for family/carer?

What is the person's preferred way(s) of communicating?

If the person is not able to speak, what other means of communication does the person have:

…….
How does the person need to receive and understand information?

…….

5. Other people living at the referred person's address (indicate main carer / next of kin / partner)

Name	Gender	Relationship to person referred	Age/DOB	School/Nursery

6. Other significant others not living at the referred person's address

Name	Gender/ Age	Address	Telephone	Relationship to person referred

7. GP details

Name	Address	Telephone	Fax	Email

8. Any health concerns e.g. health conditions; sensory problems, mental health problems, additional diagnoses, causing significant harm to self or others.

9. Access arrangements for the property/safety issues for visitors/safeguarding information/reasonable adjustments

10. Is the person currently receiving any services?

Social Care:

Health:

Independent or Voluntary Sector:

Referrer's Signature: Date:

Please send paper referrals c/o the Health Team Manager or to the team nhs.net address.

For clients in the North of the city: Crescent Bank, Humphrey St, Crumpsall, M8 9JS
Tel: 0161 861 2958, mft.northcldt@nhs.net

For clients in the Central of the city: Hulme District Office, Ground Floor, 323 Stretford Rd Manchester , Hulme, M15 4UW Tel: 0161 219 2587/2555, email: mft.centralcldt@nhs.net

For clients in the South of the city: Etrop Court, Rowlandsway, Wythenshawe
M22 5RG Tel: 0161 219 6022, mft.southcldt@nhs.net