

**TEAM REFERRAL TO**

**COMMUNITY ADULT LEARNING DISABILITY TEAM**

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| --- | --- | --- | --- |
| Patient Details | | Carer Details | |
| Name:  DOB:  CHI:  Care First No: | | Name:  Designation: | |
| Address:  Postcode: | | Address:  Postcode: | |
| Tel. No:  Mobile No: | | Tel. No:  Mobile No: | |
| Next of Kin – Name, Relationship and Address: | | | |
| Living Alone: | Or with Family: | | Or in Supported Accommodation: |
| Does this person have a guardian? Y/N  If YES, Name, Address and Phone Number –  Consent to Referral:   1. Verbal  Client 2. Signature of client/guardian  Parent/guardian   In the absence of capacity to consent to this referral is there a valid section 47 certificate in place? Y/N | | | |
| Is there any identified risk? Yes / No  If Yes, please identify risk: | | | |
| Services available are: (please tick service required). | | | |
| Team Referral  Clinical Psychology Community Nursing  Dietetics | | Occupational Therapy  Physiotherapy  Psychiatry  Speech & Language Therapy  Social Work | |
| Reason for referral / Presenting Problem (Please give as much information as you can e.g., has a diagnosis of an LD been made, what you hope the LD service will provide to the individual) | | | |
| GP Name and Address: | | | |
| Signature: Date:  Print Name in Block Capitals:  Designation: Contact Phone Number: | | | |

**On completion please send this referral to:**

Community Learning Disability Team

The Moray Council, Council Offices

10 High Street

Elgin

Moray

IV30 1BX

Tel: 01343 563211

Email: [GRAM.MorayCommunityLearningDisabilityTeam@nhs.scot](mailto:GRAM.MorayCommunityLearningDisabilityTeam@nhs.scot) or [learning.disability@moray.gov.uk](mailto:learning.disability@moray.gov.uk)

**ADMIN USE ONLY**

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| --- | --- |
| **Referral received by:** |  |
| **Date received:** |  |
| **Open to:** |  |
| **Accepted by:** |  |
| **Rejected:** |  |
| **More Information required:** |  |
| **Date response letter sent to referrer:** |  |