

# Adult Social Care Referral Form

(For use by professional agencies)



## REFERRAL MADE BY

<b>Name :</b>	<b>Address :</b>	<b>Tel No :</b>
	<b>Post Code</b>	
<b>Profession/Relationship:</b>	<b>Agency/Team :</b>	<b>Date:</b>
<b>Have you discussed &amp; obtained agreement for this referral? YES / NO</b> If no – does it meet one of criteria to continue without permission? Mental Health / Abuse or neglect / At risk		

## REFERRAL AND BASIC INFORMATION

<b>FIRST NAME(S) SURNAME</b> (Known as)				<b>TITLE</b>	<b>DATE OF BIRTH</b>	<b>GENDER</b>  M F		
<b>PERMANENT ADDRESS</b>				<b>CURRENT ADDRESS / LOCATION IF DIFFERENT</b>				
<b>POSTCODE :</b>				<b>POSTCODE:</b>				
<b>PHONE No.(s) / E-MAIL</b>				<b>NHS NUMBER</b>				
<b>ETHNICITY</b>		<b>LANGUAGE</b>		<b>RELIGION</b>		<b>OCCUPATION</b>		
<b>ACCOMMODATION TYPE</b> Please circle		House	Bungalow	Flat	Ground Floor 1 <sup>st</sup> Floor 2 <sup>nd</sup> Floor	Sheltered	<b>TENURE</b> Owns property Private rented	Social Rented Lives rent free Not applicable
<b>HOUSEHOLD COMPOSITION</b> Please Circle		Couple	Multiple	Single	Single with Children	2 adults + children	Extended family group	
<b>ALERTS</b> Please Circle		Cared for	Cares for another person	Has Allergies	Requires Interpreter	Requires Signer	Has Pet(s)	

## REASON FOR REFERRAL

Why is an assessment needed? What difficulties is the person having? What sort of help is requested? Are there other areas where help may be needed? Are there allegations of abuse or neglect? How urgently is help needed?

**HOSPITAL ADMISSIONS (Section 2 & 5 questions relevant to hospital discharge only)**

Is the person currently in hospital? YES / NO	Hospital	Ward	Date Admitted
Section 2 issued - date		Section 2 withdrawn - date	
Section 5 issued – date		Section 5 withdrawn - date	
Has the person recently been in hospital? YES / NO		What date were they discharged?	

**HEALTH CONDITIONS OR DISABILITIES**

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**HAS THE PERSON BEEN REFERRED TO OTHER TEAMS OR AGENCIES?**

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**CURRENT SUPPORT**

Detail any help or support received – list services and also support from family, friends or carers:

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**COMMUNICATION NEEDS YES / NO**

Preferred first language, sensory impairment, speech and language difficulties, language used/interpreter needed:

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**GP DETAILS**

NAME	NAME OF PRACTICE/PLACE OF WORK	TEL No.

**OTHER PROFESSIONALS INVOLVED**

NAME	NAME OF PRACTICE/PLACE OF WORK	TEL No.

**OTHER SIGNIFICANT PEOPLE – RELATIVES/FRIENDS/CARERS**

<b>FULL NAME :</b>	Relationship	Date of Birth (if appropriate)	Gender
Address		Tel No	
Post Code			
<b>FULL NAME</b>	Relationship	Date of Birth (if appropriate)	Gender
Address		Tel No	
Post code			

**ANY KNOWN HAZARDS TO LONE WORKERS YES / NO**

List potential hazards for staff to be aware of e.g. potentially violent / dangerous dogs / isolated property etc

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# **Adult Social Care - Learning Disability Screening Tool**

*(Please complete with Referral Form if Learning Disability Referral)*



**Who are the important people in the persons life – Family / Friends / Carers / Partners**

**Does the person have any communication or support needs that we should consider when meeting with them? – Language / Sensory Impairment / Advocacy**

**What is the best way to contact the person? Tick all that apply**

Telephone	<input type="checkbox"/>	E-mail	<input type="checkbox"/>	Office Appointment	<input type="checkbox"/>	Letter	<input type="checkbox"/>	Home Visit	<input type="checkbox"/>	Via their Carer	<input type="checkbox"/>	Other	<input type="checkbox"/>
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**Has the person been formally assessed as having a learning disability?**

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Specialist Schooling	<input type="checkbox"/>	Support Needs	<input type="checkbox"/>	IQ Scale	<input type="checkbox"/>
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Give Details of Special School Attended / Whether the person can meet their own personal care & support needs  
 Whether they are able to go out alone / find their way around time / Whether they are vulnerable to exploitation by others.