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**EAST KENT MENTAL HEALTH OF LEARNING DISABILITY (MHLD) TEAM REFERRAL FORM**

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| **Date of referral:** |
| **Title Forenames: Surname: Gender: Date of Birth:** |
| **NHS Number:** |
| **Home address: Post code:** **Tel Number:** |
| **Type of accommodation** (e.g. own home, supported living, residential)**:**  **Person lives with:** *(e.g. parents, partner, alone)* |
| **Next of Kin:** Name: Relationship to Client: Address: Postcode: Tel: |
| **Marital Status:**  **Ethnicity:**  **Employment Status:** |
| **What important relationships does the person have?** |
| **Referrer**  Name: Role:  Contact details: |
| **GP Details** (if not referrer)  Name:  Address:  Tel No:  Email address: |
| **Has this person been open to CAMHS within the last 8 years?**  Yes 🞎 No 🞎  Details: |
| **Is the person open to Social Services?**  Yes 🞎 No 🞎  Details:  **Is the person open to a Community Learning Disability Team?**  Yes 🞎 No 🞎  Details: |
| **Learning Disability**  Please provide evidence of learning disability eg P*revious Statement of Educational Needs or Education, Health and Care Plan (EHCP), Special Schooling, IQ Tests, Social/adaptive functioning (Daily Living Skills) assessments e.g. by Nurse or Occupational Therapist*  Please give details of any attached information here:  Please provide evidence of mental illness:  Has the person previously been open to MHLD?  🞎 Yes No 🞎 |
| **Medical History (including information on other diagnoses, relevant investigation and medications and other treatments):** |
| **Reason for referral:**  Description of presenting problem(s) – e.g. how long has the problem been apparent, how often it occurs, how is the problem currently managed, who is this problem for?  What may be achieved as a result of MHLD input? What do you envisage as the outcome of this referral? |
| Summary of Risk Issues (including aggression, self-harm, self-neglect, vulnerability from others): |
| Are there any possible Adult and/or Child Safeguarding issues? Yes 🞎 No 🞎  Details: |
| **How does the person communicate?**  **Do they have specific communication needs?**  Yes 🞎 No 🞎  Details: |
| **Mobility needs?**  Yes 🞎 No 🞎  Details: |
| **Sensory needs?**  Yes 🞎 No 🞎  Details: |
| **Capacity to consent to referral:** The Mental Capacity Act (2005) says we have to make sure our service users consent to this referral. If a person lacks the capacity to consent, a best interests’ process must be followed.  **Please complete the following questions:**  Person is able to consent to this decision: 🞎 Yes    What is their view on the referral? What are they hoping it will achieve?  Person is unable to consent to this decision: 🞎 No or unsure  🞎 It has been agreed from a Best Interest Discussion. that this referral is in the person’s best interests.  People consulted: |
| **Please return this entire form via email to** [**kmpt.eastkentmhld@nhs.net**](mailto:kmpt.eastkentmhld@nhs.net)  **Please note that failure to fully complete this form could lead to a delay in processing the referral**  If you have any queries, please email **kmpt.eastkentmhld@nhs.net** or telephone **01843 854208 / 01843 854228**.  **We aim to acknowledge this referral within 5 working days. We will send a copy of the referral outcome letter to you and the person you have referred. If you do not think that this will be appropriate, or if you think that there is anybody else that should receive this information, please indicate this here:**  ***Insufficient/incomplete information may delay this referral being processed.***  ***Please note that under the data Protection Act those referred may have the right to see this referral.*** |