Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

(OFFICE USE ONLY)				
File No				
Paris ID				
Date Received				
Entered on Local Record/Index Card				
Entered on NYLD Central Register				
Paper File Retrieved for Triage				
Input on PARIS				1h
Date Triaged				4h
Time Triaged	:			
Duty staff initials				
Initial Allocated Profession				
Initial contact (date)				24h
Confirmation Letter sent (date)				72h
Appointment Date/Time				

North Yorkshire Learning Disability Service Referral Form

(Last updated 15.03.16)

Please complete as much information as possible to prevent delay to the referral process

URGENCY LEVEL (please circle)	
Routine?	Urgent?
If urgent why?	

ON COMPLETION PLEASE SEND TO:

Email: tewv.NYLDreferrals@nhs.net

Post: Learning Disability Service, Eastfield Clinic, Westway, Eastfield, Scarborough, YO11 3EG

Tel: 0300 123 3007 (AVAILABLE DURING OFFICE HRS 9.00 – 5.00)

Person Referred				
Is the person aware of and agreed to the referral and if not why? *(Please note the referral cannot be processed if this section is not complete).*	**YES**		**NO**	

Surname:		**DOB**	
Forename:		**NHS N^{o} (If known)**	
Preferred Name:		**Gender:**	Female
Marital Status:		**Sexuality:**	
Address		**NEXT OF KIN/CARER/CURRENT SUPPORT SERVICES**	
		Name	
Postcode		**Address**	
Home and or MobileTel No:		**Postcode**	
Accommodation	**Settled Yes/No:**	**Tel No**	
	Type:	**Relationship**	

Referrer's Details (please include details of a representative who can support the assessment in your absence)			
Name (inc title)		**Address:**	
Designation			
Team / Organisation		**Postcode:**	
Date referred:		**Tel No:**	

GP Details			
GP Name		GP Tel No:	
GP Surgery		Postcode	
Address		GMP code if available:	G

Additional patient details required:				
Has the client been seen by the LDS team before?	YES	X	NO	

Does the person being referred have a learning disability?

YES		NO		UNSURE	

Does the person need support to book/attend and appointment? If yes please give details of how to contact the patient:	

First Language:		Is an interpreter required? please give details	
Nationality:		Employment Status?	
Religion:		How many hours?	
Ethnicity:			

Other Professionals involved (please give details of name, address and telephone number)		

What specific health needs to you want help with?

IS INPUT REQUIRED URGENTLY – IF SO WHY?	
Which profession do you require help from?	

COMMUNITY RISK ASSESSMENT
THIS SHOULD BE COMPLETED BY THE REFERRER

CLIENT NAME:			PARIS ID:			
Lone worker Risk Assessment Completed with			REFERRER		GP	
RISK AREA	YES	NO	ADDITIONAL INFORMATION			
Individual						
Does the individual have any history of violence/abuse/bullying/domestic violence?						
Are there or have there ever been any safeguarding concerns? If so please specify						
Has the individual been diagnosed with: • mental health disorders • personality disorder • learning disability • Are there any adult protection concerns?						
Does the client use drugs/alcohol/substances and does this pose a risk to staff?						
Does the client have a history of offending/challenging behaviour?						
Does the client have a previous history of inappropriate sexual behaviour?						
Does this client have any sensory impairment?						
Date of Risk Assessment		Signature				

If this person is not known to Learning Disability Service a Lone Worker Community Risk Assessment Form 1 must be completed by an LDS Clinician.

Other useful information: (Medical history, current medication, current social circumstances, family history, previous treatment/therapies, environmental issues at household i.e. lighting, pets). Please forward any reports/documents that may be useful.