

**Hull & East Riding Children’s Learning Disability Team**

**Referral Form**

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| **Guidance: Please read prior to completing the referral form**   * **Intellectual / Learning Disability is a lifelong condition and is categorised by 3 main criteria: -**  1. Significant impairment of intellectual functioning This means difficulties understanding, learning and remembering new things and in generalising any learning to new situations. This generally refers to an IQ of 69 or less. 2. Significant impairment of adaptive or social functioning. This means difficulties with a number of social tasks, for example communication, self-care, awareness and health and safety. This means a young person may struggle to cope on a day-to-day basis with the demands of their environment. 3. Age of onset is before adulthood.  * **Please ensure that the consent to refer is explained to the parent / carer / young person giving consent for assessment and is read and understood before they sign it.** * **Please attach any relevant information / documents to support this referral.** | |
| **Child/Young Person’s Details** | |
| **Name:** | **Date of birth:** |
| **Address:** | **Telephone number:**  **Home:**  **Mobile:** |
| **NHS Number:** | **Is the child/young person Looked After? YES/NO** |
| **Ethnicity:** | **Spoken language:**  **Is an interpreter needed?** Yes / No |
| **GP name and address:** | **GP Telephone number:** |
| **Any accessibility needs? (wheelchair access, accessible toilet etc required? Hearing or vision adaptations?)** | |
| **Referrer Details** | |
| **Name:**  **Contact number:**  **Contact email:** | **Contact address:**  **Signature:**  **Date of referral:** |
| **Consent to Refer** | |
| **Please discuss the process with the child/young person. Where they are able to decide for themselves whether the assessment / intervention should go ahead (or not), please ensure they are happy to proceed and (if they agree) please request their written consent below.**   * **Where Parent/Carer is consenting on child’s behalf**   What does the child understand about this referral? (Please show relevant information)  Have they any worries or concerns regarding the process?   * **Where Child/Young Person is consenting for themselves**   Do you feel you understand why this referral has been made?  Have you any worries about what will happen?  To be completed by Parent/Carer or Child/Young Person ***[please read carefully and******delete sections in bold* *as appropriate*]**  I give my permission for **[my child / myself]** to be referred for assessment and intervention with the Children’s Learning Disability Team  I have been informed of the purpose of this referral and understand what it involves.  I understand that a referral does not guarantee an assessment / intervention will be completed but it will be considered by the Children’s Learning Disability Team  I agree that the Team may seek and store information from other professionals (including medical or other health specialists) who are or may become involved with planned aspects of care.  I also give permission for the Team to share/request relevant information and opinions about **[my child / myself]** with professionals involved. This could include Community Paediatricians, Speech and Language Therapists, Education Psychologists, Clinical Psychologists and others as appropriate.  I understand that I can withdraw this consent at any time by informing the referrer above or by contacting the Children’s Learning Disability Team.  I understand that information will be retained for as long as is necessary to determine the appropriate course of action and that records will be maintained in line with the Humber NHS Teaching Foundation Trust Records Management Policy.  **Name of Parent/Carer or Child/Young Person (please write clearly)**  **Relationship to child (if required)**  **Signature consenting to referral**  **Date** | |
| **Information about the Child/Young Person** | |
| **Additional diagnoses** (e.g. Autism epilepsy, motor disorders, intellectual disability, complex language disorders or complex mental health disorders - please attach reports if available) | |
| **Do they have a physical, hearing or visual impairment? YES/NO**  *If ‘YES’, please provide details:* | |
| **Does the child/young person take any medication? YES/NO**  *If ‘YES’, please provide details.* | |
| **School/college attended:**  **Contact details:**  **Do staff have any current, significant concerns?** YES / NO If yes, please provide details: | |
| **Are any other agencies involved with the child/young person?** (Please provide contact details and attach reports if relevant). | |
| **Tell us why you are referring (your main concerns) and the support you would like from us** | |
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| **Tell us about any risks** | |
| (for example: - risk to or from themself / risk to the child from others / risk from the child to others / criminal behaviours or trouble with the police / substance use / absconding / school exclusion / placement breakdown) | |
| **Are any other agencies involved with the child/young person? (Please include any professionals or services who were involved in the past.)** (Please provide name and contact details and attach reports if relevant).   |  |  |  |  | | --- | --- | --- | --- | | **Profession** | **Name of professional** | **Current involvement**  √ / x | **Report/s**  **Attached**  √ / x | | **Paediatrician** |  |  |  | | **Speech and Language Therapist** |  |  |  | | **Occupational Therapist** |  |  |  | | **Social Worker** |  |  |  | | **Educational Psychologist** |  |  |  | | **CAMHS** |  |  |  | | **Other (please specify)** |  |  |  | | |
| **Please email completed forms to**: - [hnf-tr.hullandeastridingneurodiversityservice@nhs.net](mailto:hnf-tr.hullandeastridingneurodiversityservice@nhs.net)  **OR post to: -** Neurodevelopment Team  Westend  2062-2068 Hessle Road  Hull. HU13 9NW | |
| **Thank you for completing this form.** | |