

 **TEAM REFERRAL TO**

**COMMUNITY ADULT LEARNING DISABILITY TEAM**

|  |  |
| --- | --- |
| 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/NIf 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 / NoIf 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 or learning.disability@moray.gov.uk

**ADMIN USE ONLY**

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