***For referral to:* Children’s Learning Disability Health Team (CLDT)**

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| **1. Details of child or young person** |
| First Name/s  |  | Surname |  |
| Previous/AKA |  | NHS Number/ Paris ID |  |
| Date of Birth |  | Age |  | Lives with |  |
| Current Address : |
| Post Code:Email: | Tel No:Mobile No:  |
| Type of Accommodation: | Gender: Male: [ ]  Female: [ ]  | Place of birth: | Religion:[if known] |
| Current School/College: | Address: |
| Disability/ diagnosis:[*please describe the nature of disability – including any support that may be needed by parent/carers or YP in completing any forms sent]*    | Current Status: [*i.e. Looked after, any legal order?*] |
| GP: | AddressTel.No |
| **Ethnicity: (please tick the appropriate box)** | First Language: | Interpreter Needed: Yes : [ ]  No: [ ]  e  |
| White: British |  | Asian or Asian British: Bangladeshi |  |
| White: Irish |  | Asian or Asian British: Any other Asian background |  |
| White: Any other white background |  | Black or Black British: Caribbean |  |
| Mixed: Mixed white and black Caribbean |  | Black or Black British: African |  |
| Mixed: Mixed white and black African |  | Black or Black British: Any other black background |  |
| Mixed: Mixed white and Asian |  | Other Ethnic Groups: Chinese |  |
| Mixed: Any other mixed background |  | Other Ethnic Groups: Any other Ethnic group |  |
| Asian or Asian British: Indian |  | Not stated |  |
| Asian or Asian British: Pakistani |  |  |  |
| **2. Referral Details: Date Completed:** |
| **Parent / Carer Name:** | **Referrer Name:**  |
| Date of Birth |  | Relationship to child/Profession |  |
| Address: [if different] | Address: |
| Post code:Email: | Tel No:Mobile No: | Post Code:Email: | Tel No:Mobile No: |
| Relationship to child: | Parental Responsibility? Yes : [ ]  No: [ ]   | Child Seen? Parent Seen?  |  Yes : [ ]  No: [ ]   Yes : [ ]  No: [ ]   |

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| **3. Reason for this referral:** |
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| **Has there been, or is there any Domestic Abuse at home? -**  **Yes** **[ ]  No** **[ ]** Comments: |
| **Have parents/carers consented to this referral –** (please circle) **Yes / No** **If ‘no’ reasons why?** |
| **Has there been, or is there currently involvement from the Common Assessment Framework process (CAF)?****-**  **Yes [ ]  No [ ]** Comments: |
| **4. Description of concerns:** [*please attach any reports or additional information*] |
| A: Current situation: Please describe what is happening, where and when, how often and how long giving examples if possible include any current medications or treatment. |
| B: History: please explain the background to the problem, is it getting worse or staying the same? What has been tried, what has worked so far? |
| C: Child/Young Person’s Family History: please add any relevant information. |
| D: Other: Is there any thing else that may be influencing the current difficulties? *(eg environment or domestic changes)* |
| E: Details of any other Agency or Professional involvement, Past or Present? *(include contact information and enclose reports where appropriate)* |
| F: What Service/s are you requesting from CLDT and what would you like to happen? |
| ***Please note that ALL fields must be completed. Referrals received with insufficient information will be returned to referrers for completion, prior to them being considered by CLDT for assessment.*** |

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| **Administration only:** |
| Referral not accepted - State Reason: | Signposted to: |
| Referral Accepted:Status: | Service: |
| Referral Time: | Referral Priority: |
| Accepted by: | Accepted Date: |
| Referral Outcome: |  |

***Please send completed forms to:***

**Children’s Learning Disability Health Team (CLDT)**

**First Floor**

**St Edmunds**

**Victoria Park Road**

**Torquay**

**Devon**

**TQ1 3QH**

**Or e-mail to:** **cldt.torbay@nhs.net**

***Tel: 01803 656570***