***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: | | | | | | | | | | | Address  Tel.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**](mailto:cldt.torbay@nhs.net)

***Tel: 01803 656570***