**Please note, referrals will only be accepted if the following criteria is met** (If this is a repeat referral for a known person you do not need to complete the Criteria section)

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| **To meet the Criteria for having a learning disability**  **The person will have an IQ under 70 and** **all** **three factors below must be present. Please provide evidence where possible**  **1.** The person has difficulties that started in the early developmental years of childhood.  **Possible Cause or Diagnosis if known:**  **2.** The person will have had significant difficulties at school resulting in them having a **EHCP or SEN.** Attendance at a special school or the need for additional support at mainstream school. **Schools attended:**  **3**. Significant challenges with independence as an adult in at least 2 major domains of adaptive functioning (not explainable by other difficulties such as mental / physical health, substance abuse or social factors).  **Areas of adaptive functioning affected**: | **Service Eligibility**  To be eligible to access specialist health services from the Community Adult Learning Disability Team the person must:   * Be 18 years old or approaching their 18th birthday if they have complex needs. * Be registered with a Manchester GP. * Meet the criteria of having **a learning disability** and have **needs that cannot be met by mainstream services with reasonable adjustments.** * Have a presenting health need requiring intervention from a member of the multidisciplinary team |
| **Exclusion Criteria**   * Specific Learning difficulties eg: dyslexia, dysgraphia, dyscalculia or dyspraxia. * ADHD without evidence of an LD * Autism (ASD) without evidence of LD * Sensory Processing Disorder without evidence of LD |

**Please complete the referral form in FULL. Failure to do so will result in delays and the form may be returned requesting more information. Evidence of LD and supporting documentation must be attached when prompted.**

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| **Who are you referring?** | **First name** | | | **Surname** |
| **Preferred Names:** |  | | |  |
| **DOB:** | **NHS number** | | | **Religion** |
| **Pronouns Used** |  | | | **Home phone number** |
| **Ethnicity** | | | | **Mobile number** |
| **Address including postcode** | | | | **Email address** |
| **How would the person prefer to be contacted?** |
|  |
| **Social situation** *(e.g. lives alone, name of provider)* | | | | |
| **Interpreter required? Yes  NO ,** if yes, **which language?** | | | | |
| **Has the person consented to this referral? Yes  NO**  **If No, please state why:** | | | | |
| **Is this person currently under any legal framework? (please give details)** | | | | |
| **Next of kin details:** | | | **Does the person have an Advocate or Deputy for Health and Welfare?** | |
| **Reason for referral**   * **What has prompted you to make this referral now?** * **Please describe the current situation, when it started including any recent changes/ life events that have occurred in the person’s life:** * **How has this impacted on both the person and any other relevant people?** * **What improvement(s) would you expect to see as a result of this referral?** * **Has this person been seen by this service in the past Y/N/ Don’t know** | | | | |
| **Are you providing any further documentation to support this referral ¨**  *E.g.: evidence of LD, ABC charts, incident reports, discharge summary* | | | | |
| **Funding Arrangements** | | **Social Care  CHC  Section 117** | | |
| **Action already taken / Current plan and levels of support being offered:** | | | | |
| **Have you attached any support plans to this referral?  Yes  No**  *E.g., PBS Plans, Epilepsy care plans, Moving and Handling plans* | | | | |

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| **Any risks known or reported when working with this person – this includes risk to the person themselves. Please give details:**  **Communication Issues:  Yes  No**  **Details:**  **Family or Friends:  Yes  No**  **Details:**  **Forensic / Police History:  Yes  No**  **Behaviour that challenges:  Yes  No**  **Physical Disability / Moving and Handling:  Yes  No**  **Home Environment:  Yes  No**  **Other (Please State):  Yes  No** |
| **Have you attached copies of any risk assessments in place?  Yes  No** |

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| **GP details** | **Telephone** |
| **GP address or practice stamp**  **Email** | |

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| **Referrer details** | **Referrer name** | |
| **Job title** | | |
| **Telephone** | | **Email** |
| **Referrer signature Date** | | |
| **Please note that it is good practice to discuss potential referrals before submitting them. If you have done this, please provide the name of the person working for CALDS that you have spoken to:** | | |

**Community Learning Disability Teams in the Manchester city area:**

**CALDS South** - Etrop Court, Rowlandsway, Wythenshawe, M22 5RG 0161 219 6022

**CALDS Central** - Hulme District Office, 323 Stretford Road, M15 4UW 0161 219 2555

**CALDS North** - Crescent Bank, Humphrey Street, Crumpsall, M8 9JS 0161 861 2958

Please submit completed referral forms to: [mft.calds@nhs.net](mailto:mft.calds@nhs.net)

**Referrals to social care for Social Worker allocation and a Care Act assessment should be made to Manchester City Council via the Contact Centre on 0161 234 5001 or email:** [**mcsreply@manchester.gov.uk**](mailto:mcsreply@manchester.gov.uk)