| Patients Name: | | | | | | | | | | NHS No: | | | | | | | | | | | | | | G:\PCHComms\New identity for PCH\LIVEWELL _LOGOS\LIVEWELL _LOGOS\Livewell.png | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Referral and Health Needs Assessment v1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Family name | |  | | | | | | | | | Given name | | | | | | | |  | | | | | | Preferred name | | | | | | |  | |
| Title | |  | | | | | | | | | Date of Birth | | | | | | | |  | | | | | | Marital status | | | | | | |  | |
| Gender | |  | | | | | | | | | Preferred language | | | | | | | | | |  | | | | | | | | | | | | |
| Address and Postcode (please enter current address If different from home address) | | | | | |  | | | | | | | | | | | Mobile number | | | | | | | | |  | | | | | | | |
| GP Practice & contact number | | | | | | | | |  | | | | | | | |
| Employment status | | | |  | | | | | | | | | | | | | Ethnicity | | | | |  | | | | | | | | | | | |
| Phone number | | | |  | | | | | | | | | | | | | Religion | | | | |  | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Next of kin** |  | | | | | | | | | | | | | | **Other** | | | | | | | | |  | | | | | | | | | |
| Relationship |  | | | | | | | | | | | | | | Relationship | | | | | | | | |  | | | | | | | | | |
| Tel no |  | | | | | | | | | | | | | | Tel no | | | | | | | | |  | | | | | | | | | |
| Address |  | | | | | | | | | | | | | | Address | | | | | | | | |  | | | | | | | | | |
| Risks *(including risk of harm or neglect to self/ harm to others or abuse from others/ placement breakdown/ safeguarding)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *(access details – key safe, hard of hearing)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referral details **(If self-referral address will be assumed to be as above. If in hospital identify person’s ward)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referral date & time | | | | |  | | | | | | | | Referrer name & designation | | | | | | | | | | | | | | | |  | | | | |
| Referral source | | | | |  | | | | | | | | Contact telephone number | | | | | | | | | | | | | | | |  | | | | |
| Expected date of discharge (inpatient only) | | | | | | | | |  | | | | | | | | | | | Confirmed date of discharge | | | | | | | | | | |  | | |
| Date 1st visit required (Community Nursing only) | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | |
| **Reason for referral:**  (Is there a prescription chart available)  Is the client aware of the referral? (consider capacity to consent to being referred. Capacity needs to be decision specific) Yes/No If no why not?  **If the person is not known to CLDT please complete the following sections otherwise the referral may be rejected.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Does the person have any other diagnosed condition** *(ie autistic spectrum condition, ADHD, sensory impairment, physical disability)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Developmental History** *(ie developmental milestones, schools/colleges attended, qualifications gained, any significant trauma that has occurred during childhood)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Employment History** *(volunteer, paid work, how long a job lasted)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Daily Living Skills** *(ie is the person able to cook, follow instructions, pay bills)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Relevant Medical History** *(ie medication currently taken/recent hospital admissions)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Allergies** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Printed name of person making the referral: Date:**  Signature: Designation: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The individual being referred agrees that this referral may be shared as needed to support their care: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | |  | | | | | Yes, but with  Limitations | | | |  | | | | | | No | | | | |  | | | | | | | Unable to consent | | |  |
| Details of any limitations to share information : | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient signature | | |  | | | | | | | | | | | | | Date | | | | | | | | | | | |  | | | | | |
| Referrer  signature | | |  | | | | | | | | | | | | | Date | | | | | | | | | | | |  | | | | | |
| Print name of referrer | | |  | | | | | | | | | | | | | Designation of referrer | | | | | | | | | | | |  | | | | | |

Please return the referral via the following secure email address

[Livewell.cldtreferrals@nhs.net](mailto:Livewell.cldtreferrals@nhs.net)

Or by post to

Community Learning Disabilities Team

Westbourne, Scott Business Park, Beacon Park Road, Plymouth, PL2 2PQW