| 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 |  |
| Referrersignature |  | Date |  |
| Print name of referrer |  | Designation of referrer  |  |

Please return the referral via the following secure email address

Livewell.cldtreferrals@nhs.net

Or by post to

Community Learning Disabilities Team

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