

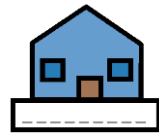



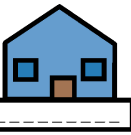

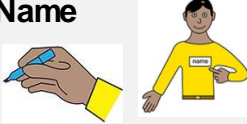

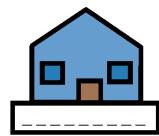





LEARNING DISABILITY LIAISON SERVICE – REFERRAL

Date of referral -

| Person Referred | | | |
|--|--|---|--|
| Name:  | | Date of Birth  | |
| Address  | | Telephone Number  | |
| | | NHS N° (if known) | |
| Main Contact (Family, Carer, Care provider) | | | |
| Name  | | Telephone Number  | |
| Address  | | Relationship  | |
| Person Making This Referral | | | |
| Name  | | Telephone Number  | |
| Address  | | Relationship  | |

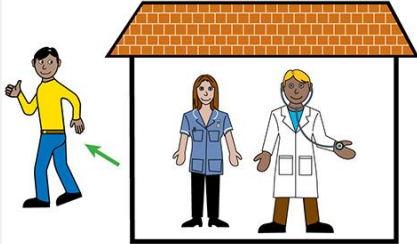
| | | | |
|--|--|--|--|
| <p>Does the person or their family / carers know about this referral?</p>  | | <p>Who is the best person to speak to about this referral?</p>  | |
|--|--|--|--|



Reason For Referral


| | | |
|--|--|---|
| <p>Does the person have a hospital appointment?</p>   | | <p>yes no</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <input checked="" type="checkbox"/> </div> <div style="text-align: center;"> <input type="checkbox"/> </div> </div> <p>Yes No</p> |
|--|--|---|

| | | | |
|---|------------------------------------|---|--|
| <p>When?</p>  | <p>Ongoing appointments</p> | <p>Where?</p>   | |
|---|------------------------------------|---|--|

About the patient



| | | | |
|--|--|---|--|
| <p>How does the person communicate?</p>  | | <p>Other professionals involved</p>  | |
|--|--|---|--|



Other useful additional information:

(Medical history, current social circumstances, previous treatment, specific behaviours. Please forward any reports/documents that may be useful.)

Please send completed forms to



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