

Inverclyde CLDT Referral / Cross Referral Form

Inverclyde Community Learning Disability Team

**Port Glasgow Health Centre,
2 Bay Street, Port Glasgow,
PA14 5EW,
Tele 01475 715295**

Referral Form

Cross Referral Form

Return completed form to:

Email: CLDT@inverclyde.gov.uk

Post: **Inverclyde Integrated Community Hub
12 Brachelston Street
Greenock
PA16 9AD**

Does the client have or live with children?

Yes No

Details:

Are there any adult or child protection issues?

Yes No

Details:

Emergency

Requires input same day
(psychiatry/nursing only).

Urgent

Requires to be seen within 5 working
days.

Routine

Requires to be seen
within 12 weeks.

If the referral is an emergency or urgent give detail reasons why.

Person(s) full name:

CHI Number:

Welfare Guardianship?

Yes No

Date commenced:

Title:

Gender:

Financial Guardianship?

Yes No

Date Commenced:

Preferred name:

Ethnic Background:

Section 47 Certificate?

Yes No

Reason why?

Date of Birth:

Religion:

Compulsory Treatment Orders?

Yes No

Lives alone: Yes **No**

(if No please give details of living arrangements)

Other – give details:

Referrer			
Name of Referrer:		Profession:	
Address:		Tele:	
		Mobile:	
		E-mail:	
Postcode:			
Does the person and proxy agree with the referral?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the person and proxy agreed to disclosure of information to the team?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the person and proxy agreed to access of information?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Reason for assessment:			
Present address:		Principal Carer:	
Address:		Name:	
		Relationship to person:	
		Tele No:	
		Mobile No:	
Postcode:			
Tele No:			
Contact details:	Next of Kin:	Name of GP / Practice:	Support Provider:
Name:			
Address:			
Postcode:			
Tele No:			

Communication Needs
Preferred language?
Is an interpreter required?

How does patient communicate and the level of support needed (speech, sounds, pictures, objects, signing).

Any other factors affecting communication?

Relevant Background History

To include where appropriate: Work/employment, family, marital status, pregnancy/suspected pregnancy religion, any other factors – Housing/Accommodation issues, recent change in abilities/function, concerns, risks, social network, bereavement.

Relevant medical history (including current medical conditions and medication).

Other risks/concerns, e.g. safe to visit alone/ Alerts in place – Give details.

Referrer signature Date

Inverclyde Community Learning Disability Team

Client
Name

.....

Received by CLDT Office on By

.....

Team Meeting Form – To be completed by CLDT staff only

New Referral

Emergency

(same day – psychiatry / nursing)

Urgent

(5 working days)

Routine

(4 weeks)

Agreed level of priority by the CLDT team.....

Cross Referral

Emergency

(same day as allocation)

Urgent

(5 working days from allocation)

Routine

(12 week from allocation)

Agreed level of priority by the CLDT team.....

Additional Notes:

Outcome from the team meeting:

Completed by (please print)

Signature:

Designation:

Date: