DATE STAMP

Directorate of Learning Disability Services

ABM
Ymddiriedolaeth Prifysgol GIG Abertawe Bro Morgannwg
University NHS Trust

REFERRAL FORM

Please complete in black ink providing full, accurate and clear details

Alternately, contact the Community Support Team to make a telephone referral

Confidential

Client's full name			Phone inc STD
Address		Postcode	
DoB		*Male*Female	Mobile

If known please enter the client's identity number for:				
PIMS+	NHS	Social Services	Care First	PARIS

CONSENT

Is the client aware of this referral?	Yes ☐	No ☐	Unsure ☐
Is the client in agreement with this referral?	Yes ☐	No ☐	Unsure ☐
Has the client agreed to share information?	Yes ☐	No ☐	Unsure ☐

Client's preferred / main method of communication:

Diagnosis	
Give details of current medication	

Next of Kin	Relationship to client	Phone (inc STD)
Address	Postcode	Mobile

Advocate		Phone (inc STD)
Address	Postcode	Mobile

Care Manager	Is the Care Manager aware of this referral *YES / *NO	Phone (inc STD)
Address	Postcode	Mobile

Key carer name		Phone (inc STD)
Address	Postcode	Mobile

G.P. name		Phone (inc STD)
Address	Postcode	Mobile

Current known alerts or risk assessments	Clinical Risk
Manual Handling Yes ☐ No ☐ Unsure ☐	Epilepsy Yes ☐ No ☐ Unsure ☐
Lone Worker Yes ☐ No ☐ Unsure ☐	Dysphagia Yes ☐ No ☐ Unsure ☐
Home Visit Yes ☐ No ☐ Unsure ☐	Postural management Yes ☐ No ☐ Unsure ☐
	Behaviour management plans Yes ☐ No ☐ Unsure ☐

Tick the box on the right for a SINGLE referral to the Health Team. The referral will be discussed and allocated to the appropriate profession/s at the next Referral Meeting	

OR

Tick one of the boxes below for the specific profession in relation to the reason for referral			
Arts Therapist (where available)		Occupational Therapist	
Clinical Psychologist		Physiotherapist	
Community Nurse		Psychiatrist	
Nutrition and Dietetics (where available)		Speech & Language Therapist	

Reason for referral and any other relevant information – please attach any relevant reports / correspondence

Others currently involved (please tick)	
Arts Therapist	
Care Manager	
Clinical Psychologist	
Community Nurse	
Dietitian	
GP	
Occupational Therapist	
Physiotherapist	
Psychiatrist	
Speech & Language Therapist	
Transition Worker	

Type of residence (please tick)			
Family home		Private sector residential home	
Own house/flat		Private sector nursing home	
Private sector		Family placement / Fostering	
Voluntary sector		House managed by Local Authority	
Residential college		Local Authority hostel	
Residential school		Hospital ward	
Directorate Continuing Health Bungalow		Directorate Assessment & Treatment Unit	
Other (Please state)			

Please provide names and addresses for other Medical Consultant/s

Day Service/s	Client's Attendance (please circle)						Name and address	Phone
Education:	am	M	T	W	Th	F		
	pm	M	T	W	Th	F		
Local Authority Day Centre	am	M	T	W	Th	F		
	pm	M	T	W	Th	F		
Private Sector	am	M	T	W	Th	F		
	pm	M	T	W	Th	F		
Social Care Support Worker/s	am	M	T	W	Th	F		
	pm	M	T	W	Th	F		
Voluntary Sector	am	M	T	W	Th	F		
	pm	M	T	W	Th	F		
Other (e.g Home)	am	M	T	W	Th	F		
	pm	M	T	W	Th	F		

Name of referrer		**Relationship to client**		**Designation**	
				Signature	
Address		**Phone**		**Date**	

Please send this Referral to:	**FOR OFFICE USE ONLY**	
	Received by: **Signature:**	
	Designation: **Date:**	
	Date entered onto PIMS+	
	Urgent	**Allocated to:** **Date of first appointment:**
	Routine	**Date taken to Referral Meeting:** **Allocated to:** **Placed on Waiting List:** **YES** ☐ **NO** ☐ **Date of first appointment:**