Changing Lives
Building Dreams

A service that offers 24 hour support to individuals with a learning disability, complex needs and/or a mental health diagnosis through a person centered approach. The aim of the service is to provide a safe and homely environment that promotes empowerment, independence and choice, whilst enhancing the individuals' daily living skills.

REFERRAL FORM

Once completed, please return this referral form to:

CLBD Limited
Burham Court
Court Road
Burham
Rochester
Kent ME1 3XX

Telephone No: 01634 869200
Fax: 01634 681607
Email: Debbie@clbd.org

For Official Use Only

Date/time received: Received by:

Funding agreed by CCG: Yes ☐ No ☐

Date of assessment: Assessors:

Referral Accepted ☐ Declined ☐ Waiting list ☐ Date:

People informed of decision:

Referrer	☐	Date:	By whom:	Method:
Service User	☐	Date:	By whom:	Method:
GP	☐	Date:	By whom:	Method:
Carer/Key Contact	☐	Date:	By whom:	Method:
Care Manager	☐	Date:	By Whom:	Method:
Other (specify)	☐	Date:	By whom:	Method:

Please complete all Fields

Responsible CCG:

About the Referrer

Name:	Designation:
Address: Post Code: Signature/Date:	Telephone No: Email address: Fax No:

About the Service User

Title:	Forename(s):	Surname:
Alternative name(s):		Date of Birth:
NHS No:	Age:	Gender:
Diagnosis:		Status:

Present Address: Post Code: Contact Name: Contact Number: Is this address: Temporary ☐ or permanent ☐ Length of time at present address:	Usual place of residence: Post Code: Contact Name: Contact Number: Is this address: Private ☐ or residential ☐ Length of time at this address:

<u>White</u> British ☐ Irish ☐ Any other white background ☐ (Tick and specify)	<u>Asian or British Asian</u> Indian ☐ Pakistani ☐ Bangladeshi ☐ Any other Asian background ☐ (Tick and specify)	<u>Black or Black British</u> Caribbean ☐ African ☐ Any other black background ☐ (Tick and specify)
<u>Other ethnic groups</u> Chinese ☐ Any other ethnic group ☐ (Tick and specify) Not stated ☐	<u>Mixed</u> White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Any other mixed background ☐ (Tick and specify)	Main language: Interpreter required: Y ☐ N ☐

Capacity: **Concerning Moving to a New Home**

1. Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.(learning disability)

   YES ☐ NO ☐

2. Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

   YES ☐ NO ☐

Can the person:

(a) Understand the information relevant to the decision? YES ☐ NO ☐

(b) Retain that information? YES ☐ NO ☐

(c) Use or weigh that information as part of the process of making the decision? YES ☐ NO ☐

(d) Communicate his/her decision (whether by talking or any other means)? YES ☐ NO ☐

(NB: If a person cannot do one or more of these four things, they are unable to make the decision.)

Outcome of Mental Capacity Assessment

On the balance of probabilities, there is a reasonable belief that:

The person **has** capacity to make this particular decision at this time. YES ☐ NO ☐

Or

The person **does not have** capacity to make this particular decision at this time. YES ☐ NO ☐

(please include outcome of best interest meeting/decision)

Details of Assessor

Assessor: Signature: Designation:

Date: Time:

Best Interest Meeting

Has the person had a best interest meeting regarding a move to their new home? YES ☐ NO ☐

Registered GP: Address: Post Code: Contact Number: Aware of Referral YES ☐ NO ☐	Responsible Consultant/RMO: Address: Post Code: Contact Number: Aware of Referral YES ☐ NO ☐
Nearest Relative/Next of Kin: Relationship: Address: Post Code Contact Number: Aware of Referral YES ☐ NO ☐	Care Manager/Care Co-ordinator: Email Address: Address: Post Code: Contact Number: Aware of Referral YES ☐ NO ☐

Community Nurse Email Address: Address: Post Code Contact Number Aware of Referral YES ☐ NO ☐	Psychologist Email Address: Address: Post Code Contact Number Aware of Referral YES ☐ NO ☐
Service User preference:	
Main presenting needs: **<u>Psychosocial sensitivities:</u>**	
Duration of any current Difficulties	
Which professionals have been involved with this persons care? Past/Present interventions used (by whom):	

Present accommodation/Type of support: **Current Level of Support** (e.g. 1 to 1):
Current medication (including length of time prescribed): **Drug sensitivities/allergies:**
Risk Factors: (please attach any risk assessment)
Psychological Factors:
Other relevant information (Including Mental Health Act information):

Please use additional sheets as required