South West Yorkshire Partnership NHS
NHS Foundation Trust

BARNSLEY ADULT LEARNING DISABILITIES
SPECIALIST HEALTH SERVICES

REFERRAL FORM

Client Information:

First Name:	Surname:
NHS No.:	RiO No.:
DOB:	Marital Status:
Gender :	Religion:
Ethnicity:	Preferred Language:
Address: Post Code: Landline Tel: Mobile Number: Email Address:	GP Name: Surgery Name: GP Address: Postcode: Phone Number:
Main Carer Name: Telephone Number: Address:	Relationship:
Key Relative/Friend Name: (if different from above) Telephone Number: Address:	Relationship:

Other Professionals: Relationship: Organisation: Telephone Number: Address: Other Identifier (if known):		

With **all of us** in mind.

Referral Details:

Date of Referral:	Time of Referral:
Name of Referrer: **Telephone Number:** **Address:**	**Relationship:** **Organisation:**

Reason for Referral: *Explain clearly the presenting issues and your request.*

Desired outcome:

Does Service User have capacity to consent to this referral?

YES ☐ **NO** ☐ **Don't Know** ☐

Does Service User consent to this referral?

YES ☐ **NO** ☐ **Don't Know** ☐

If referral made after best interest consideration who is responsible for making this decision?

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Preferred method of contacting Service User:

- ☐ **Letter**
- ☐ **Mobile Phone**
- ☐ **Landline**
- ☐ **Email**
- ☐ **via Carer**
- ☐ **via Family Member / Friend**
- ☐ **Other**

(Please state)

Form Completed By:

Job Title / Role:

Please return this form to :-

Via email to: swy-tr.BarnsleyCommunityLDHealth@nhs.net

Or via post to: Barnsley Adult Learning Disabilities Specialist Health Services Keresforth Centre, Off Broadway, Barnsley, S70 6RS

For further information and in all instances where your referral is **URGENT** please contact our Duty Worker as above.