Referral Form to:

Clinical Health Team for People with Learning Disabilities

Please complete this referral form with as much details as possible. The more information provided, the quicker the referral can be processed.

Eligibility Criteria The person you are referring **must**: • Be registered with a GP in Sutton • Be aged 18 years or over • Have a learning disability (not a learning difficulty) • Consent to this referral • Agree to have their information shared where appropriate	
Biographical Details	
Name: DOB:	
Address: Post Code: Telephone Number:	
Next of Kin Address: Tel No;	GP; Tel No;
Referral Details	
Referred by: Position /Role: Address; Telephone number: Email:	
Is the client known to Sutton Disability Team?	Frameworki No;
Is client able to consent to the Referral?	Is the carer aware of the referral?
If yes, does the client consent?	Is the carer in agreement with the referral?
Has the GP been informed/ involved in the referral?	Placing Authority (if client in residential care):
Social worker/Care Manager's name:	Address and phone number of team (if not LBS)
Current Situation	
Type of housing	
Other Professional /Services Currently involved:	

Diagnosis (if known) Please include level of learning disability and other health diagnoses.
Previous contact with health/community services; List, in brief, what issues were dealt with? (e.g. Respite, housing, day services, Speech & Language Therapy, Psychology etc)
Reason for Referral
Background to request for referral? (continue on a separate sheet if necessary) Please give as much detail as possible.
What do you hope the team can do for the client?
Any further information

Referral completed by: Date:

Returning this form:

Email
You can email this form to: adultsdayservice@sutton.gov.uk

Post
You can post this form to:

London Borough of Sutton,
First Contact Team,
People Call Centre
Ground Floor, Civic Offices
St Nicholas Way
Sutton
SM1 1EA