**Merton Integrated Learning Disability Team (MILD)**

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| **REFERRAL FORM – This must be returned to the MILD Team** |

**London Borough of Merton**

**London Road, Morden, SM4 5DX**

[**Tel:0208**](Tel:0208) **545 4529**

**Email: LD.Admin@merton.gov.uk**

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| **CLIENT INFORMATION:** | | | | | |
| **Date of Referral:** | | | | | |
| **Client’s Surname:** Click here to enter text | **Client’s First Name:** | | | | |
| **Marital Status:** | **Male  Female** | | | | |
| **Date of Birth:** | **Mosaic No** | | | | |
| **Address:** | **Post Code:** | | | | |
| **Type of accommodation: R** | **Telephone No:**  **Email address:** Click here to enter text | | | | |
| **Ethnic Origin/ Cultural background** | **NHS Number** | | | | |
| **Language:** Click here to enter text | **Interpreter Required: Yes No** | | | | |
| **Additional communication needs:** | | | | | |
| **Carer details:**  Name: Click here to enter text  Relationship to client: Click here to enter text  Telephone Number: 1 Email address: Click here to enter text | | | | | |
| **Who should we contact about this referral?** | | | | | |
| **GP Surgery name:** | | | | | |
| **Confirmation of correct GP details**  **What date were GP details confirmed?** | | | | | |
| **Presenting problems/issues:**  **.**  **NB Referrals relating to dysphagia (swallowing disorders) or eating, drinking, and swallowing difficulties should be sent direct to Central London Community Healthcare (CLCH). Their referral form can be accessed at**[Merton :: Central London Community Healthcare NHS Trust (clch.nhs.uk)](https://clch.nhs.uk/health-professionals/merton) **Our Speech & Language Therapy team do not manage a dysphagia caseload.** | | | | | |
| **Other Useful Information** *(e.g. physical health needs, mental health needs, current medication, past support)*  **Please supply any copies of relevant reports if available** *(e.g. IQ/Cognitive Assessments/Education Health Care Plan/Health reports/autism spectrum disorder/attention deficit hyperactivity disorder reports)*  **Has the client exhibited any verbal aggression or intimidating behaviour? Yes No** (If yes, please provide details)  **Has the client exhibited any physical aggression towards others? Yes No** (If yes, please provide details) .  **Are there any risks to entering the property should we need to visit?** (*e.g. large or nervous pets, smoking at the property, etc)* | | | | | |
| **What are you expecting that the MILD Team will do:** | | | | | |
| Has the client agreed to this referral? | | | **Yes No** | | |
| Does the client have capacity to understand the referral process? | | | **Yes No** | | |
| If NO, has a best interest decision been made about this referral? | | |  | | |
| **REFERRER INFORMATION:** | | **PRIORITY LEVEL** | | | |
| Name & where from**:** Click here to enter text.  Address (including Post Code):  Click here to enter text  Relationship to the Client: Click here to enter text  Telephone Number: Ext  Email: Click here to enter text | | Emergency (Same Day) | | |  |
| Urgent (5 working days) | | |  |
| Non-Urgent Referrals | | |  |
| **Form completed by: Noelle Cummins** | | | | | |
| **ELIGIBILITY SCREENING – Learning Disability** | | | |  | |
| **Has this client accessed Merton Integrated Learning Disability Team (MILD) team previously?** The form may now be submitted to LD admin for review – [LD.Admin@merton.gov.uk](mailto:LD.Admin@merton.gov.uk)  **NO  - PLEASE COMPLETE THE SECTION BELOW BEFORE SUBMITTING TO LD ADMIN** | | | | | |
| Does this client have a diagnosed Learning Disability - IQ below 70 with adaptive functioning difficulties (daily living skills) that were evident before the age of 18 years?: | | | | **Yes No** | |
| If **YES** please give details/provide evidence:  Click here to enter text | | | |  | |
| Did the client attend a school for people with Learning Disabilities?  *Please give the name of the school and details of ages attended:*  Click here to enter text | | | | **YES  NO** | |
| Did the client receive an Education Health Care Plan (EHCP)?  *Please give details:*  Click here to enter text | | | | **YES NO** | |
| Does the client require support to live independently?  *Please give full details:*  Click here to enter text | | | | **YES  NO** | |
| Does the person have any neurodevelopmental diagnoses?  *i.e. Autism Spectrum Disorder (ASD)/Attention Deficit Hyperactivity Disorder (ADHD)*  *Please give full details:*  Click here to enter text | | | | **YES  NO** | |