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

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

**London Borough of Merton**

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

**Tel:0208** **545 4529**

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

|  |
| --- |
| **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**[x]  **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 textTelephone 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**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** [ ]  |