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| **Children’s Community Learning Disability Nursing (CLDN) Team** |
| Please ensure the child/ young person meets the following criteria in order for the referral to be accepted: * **0-18yr olds**
* **Solihull GP**
* **Moderate-Severe Learning Disability**

We will not work with the following diagnoses unless accompanied by a learning disability/GDD:* **Mild Learning Disability**
* **Learning difficulties (dyslexia, dyscalculia etc.)**
* **Asperger’s/Autism**
* **ADHD**
* **Physical/Sensory Impairments**

The CLDN team is based within Solihull and offer a link nurse service to Solihull Special schools; **Forest Oak, Merstone, Reynalds Cross, Hazel Oak, Green Lane.** We will work with children in mainstream or other special schools around Solihull however they must have a diagnosed moderate-severe learning disability (or global developmental delay).**The Children’s Community Learning Disability Nursing Team is not an emergency service.** **For emergency out of hour’s service please contact:*** **SOLAR Crisis Team on 0121 301 5500**
* **Social Services 0121 605 6060 (Solihull) or 0121 675 4806 (Birmingham).**
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| **About this form**  |
| To avoid delay in accessing our service, please complete this form with as much detail as possible. Incomplete forms may be returned for further information. Once complete, please return this form to: solihullcommunity.childrensnursing@nhs.net with subject stating **‘FAO CLDN’** or post to:  **Community Learning Disability Nursing Team, 3rd Floor, Friars Gate, 1011 Stratford Road, Solihull, B90 4BN** |
| **About the Child / Young Person**  |
| **Name of Child / Young Person:** |  | **Date of Birth:** |  | **Gender:** |
| Please select |
| **Address:****Postcode:** |  |
| **Living with:**  | Please select | **NHS Number:**  |  |
| **Ethnic Origin** | Please select | **Interpreter Required?** | Please select | If Yes, please give details:  |
| **Religion** | Please Select |
| **Safeguarding** the child(ren) have/are | Please select | Is the child **Looked After** under the Children Act? | Please select |
| **Legal Status** | Please select | **Placing Authority**(If not Solihull): |  |  |
| **Current School/College** |  | Is there an Education and Health Care Plan (EHCP)? | Please select |
|  |
| **Does the child have a diagnosis of the following?**  | **Details** (Specific diagnosis, date of diagnosis, undergoing assessment) |
| **Learning Disability/ Global Development Delay** | Choose an item. |  |
| **ADHD** | Choose an item. |  |
| **Epilepsy** | Choose an item. |  |
| **Dyspraxia** | Choose an item. |  |
| **Hearing Impairment** | Choose an item. |  |
| **Visual Impairment**  | Choose an item. |  |
| **Sensory Issues** | Choose an item. |  |
| **Chromosomal Disorder (Please Specify)** | Choose an item. |  |
| **Other** |  |  |
|  |  |  |
| Person(s) with **Parental Responsibility** for the Child / Young Person[including Local Authority if applicable] **(please include all person(s) regardless of whether they live in the same household)** |
| **Parent / Carer / Worker Name:** |  | **Relationship to child:** | Please select |
| **Date of Birth:** |  |
| **Full Address**  |  |
| **Email Address:** |  | **Telephone Number:** |  |
| **Parent / Carer / Worker Name:** |  | **Relationship to child:** | Please select |
| **Date of Birth:** |  |
| **Full Address** |  |
| **Email Address:** |  | **Telephone Number:** |  |
| **About You (Person Requesting Support [Referrer]’s Details)** |
| **Referrer:** | Please select | **Name (and Job Title / Relationship to child):** |  |
| **Full Address:** |  |
| **Email address:** |  | **Telephone Number:** |  |
| Have you gained the **young person and parent’s consent** to contact the CLDT?  | Please select |
| If ‘no’ please detail all reasons why not: |  |
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| **About the GP (GP’s Details)****The child must have a Solihull GP** |
| **Name of GP:** |  | **Name of Practice:** | Choose an item. |
| **Telephone:** |  | **Fax / Email:** |  |

**Others involved in Supporting Child/Young Person and Family** |
| **Agency/Service** | **Involvement** | **Further details (e.g why/when were they involved) Named Person / Contact Details** |
| Please Select | Please select |  |
| Please Select | Please select |  |
| Please Select | Please select |  |
| **Reason for Referral** Please complete all areas of concern  |
| Relevant Background and Current Circumstances |  |
| Behaviour  |  |
| Sleep |  |
| Toileting  |  |
| Fussy Eating |  |
| Relationships and Puberty |  |
| Short Breaks |  |
| Other |  |
| **About Risk** |
| **Risk Factors** Please detail: Frequency (how often), Severity (how harmful), Protective Factors (what helps)Please note if a child is at risk of significant harm you must [report this as a Child Protection concern](https://solihulllscp.co.uk/report-abuse.php) in line with your policies / procedures |
| **Risk Factors** | **Risk Level** | **Further information / Details:** |
| Self-Harm/Self-Injurious Behaviour | Please select |  |
| Risk From Others  | Please select |  |
| Risk to Others | Please select |  |
| Child Exploitation | Please select |  |
| Physical Complications | Please select. |  |
| Wandering or Falls | Please select |  |
| Memory and Cognitive Impairment | Please Select | Click here to enter text. |
| **Support** |
| **What specific support would you like from the CLDN Team?**  |
| **Have you had previous support from CLDN? If so when, and what for?**  |
| **Signature of Referrer** |  | **Date** |  |