CONFIDENTIAL

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: Click here to enter text	
Client's Surname: Click here to enter text	**Client's First Name:** Forename
Marital Status:	**Male ☐ Female ☐**
Date of Birth: Click here to enter text	**Mosaic No** *(internal only)* Click here to enter text
Address: Click here to enter text **Type of accommodation:** (e.g. Parental Home, Supported Living) Click here to enter text	**Post Code:** Click here to enter text **Telephone No:** Click here to enter text **Email address:** Click here to enter text
Ethnic Origin/ Cultural background	**NHS Number:** Click here to enter text
Language: Click here to enter text	**Interpreter Required: Yes ☐ No ☐**
Additional communication needs: Click here to enter text	
Carer details: Name: Click here to enter text Relationship to client: Click here to enter text Telephone Number: Click here to enter text Email address: Click here to enter text	
Who should we contact about this referral?: Click here to enter text	
GP Surgery name: Click here to enter text	
Confirmation of correct GP details ☐ **What date were GP details confirmed?:** Click here to enter text	
Presenting problems/issues: Click here to enter text	

Other Useful Information *(e.g. physical health needs, mental health needs, current medication, past support,)*
Click here to enter text

Please supply any copies of relevant reports if available
(e.g. IQ / Cognitive Assessments / EHCP / Health reports / ASD reports)

What are you expecting that the MILD Team will do:
Click here to enter text

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?	**YES** ☐ **NO** ☐

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: Click here to enter text Email: Click here to enter text	Emergency (Same Day) ☐ Urgent (5 working days) ☐ Non-Urgent Referrals ☐

Form completed by: Click here to enter text

ELIGIBILITY SCREENING – Learning Disability

Has this client accessed Merton Integrated Learning Disability Team (MILD) team previously?

YES ☐ - The form may now be submitted to LD admin for review – LD.Admin@merton.gov.uk

NO / UNSURE ☐ - <u>PLEASE COMPLETE THE SECTION BELOW BEFORE SUBMITTING TO LD ADMIN</u>

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 a 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. ASD. ADHD* *Please give full details:* Click here to enter text	**YES ☐ NO ☐**