# Additional information – Specialist Learning Disability Service

Your child has been referred to the Specialist Learning Disability Service for assessment and advice/support. The information that you give us with this form, will help us establish if we are the most appropriate service. Please try to answer the questions in full, giving us as much information as possible. If you have difficulty in answering the questions or require some support please contact the number below and we will assist you in completing the form.

If we do not receive the completed form within 14 days we will assume that the service is no longer required, and the referral to the Specialist Learning Disability Service will be removed from our waiting list.

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| --- | --- |
| Child’s Surname | Type your response here. |
| Child’s First Name (s) | Type your response here. |
| Date of Birth | Type your response here. |
| NHS Number (if known) | Type number here. |
| Consultant Paediatrician:(if relevant) | Type your response here. |

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| --- | --- |
| Medication (please do not state dosages) |  |
| Type your response here. | |
| Type your response here. | |
| Type your response here. | |
| Type your response here. | |
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**What individual support (if any) does the child / young person receive at school?** (Please attach copies of educational psychology reports and school review if possible. Please check with the class teacher if unsure, you may want/need their support in completing this section).

For example, is your child working at their chronological age? Is your child working behind their peers? If so how far behind approximately? Is your child meeting expected targets for their year group?

How does your child communicate?

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| --- | --- | --- |
|  | Home | School |
| Does your child use visual Aids? | Type your response here. | Type your response here. |
| Does your child use verbal language? | Type your response here. | Type your response here. |
| Does your child use additional communication aids? | Type your response here. | Type your response here. |
| Does your child receive speech and language Therapy? | Type your response here. | Type your response here. |
| Can your child follow instructions of two requests? | Type your response here. | Type your response here. |
| How does your child’s communication difficulty impact on their behaviour? | Type your response here. | Type your response here. |

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|  | Area of difficulty (please only complete areas your child has difficulty in) | Please describe how this impacts on young person and family |
| **Sleep:** Please give information around current routine, night settling, night waking etc. | Type your response here. | Type your response here. |
| **Behaviour:** Any behaviour which challenges. How often the behaviour occurs. Are they linked to changes in routines, emotions, communication etc.? | Type your response here. | Type your response here. |
| **Independence skills:** Please describe level of difficulty and how this impacts on your child? Are there concerns around personal safety. Do they have difficulties with continence, washing, dressing etc? | Type your response here. | Type your response here. |
| **Health:** Are there concerns around any health issues for example epilepsy, sexual health, puberty, dental care, blood tests, inoculation’s etc. | Type your response here. | Type your response here. |
| **Other:** Please describe any additional needs not covered in the above. | Type your response here. | Type your response here. |

## Your hopes from this referral

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| --- | --- | --- |
| What are your 3 main goals that you would like help with? | 1. Type your response here. | |
|  | 2. Type your response here. | |
|  | 3. Type your response here. |  |
| How would you like things to be different? | Type your response here. | |

**Please provide any additional information you feel may be relevant:**  
(including cognitive or functional assessments, clinic letters etc.)

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| Form Completed by | Name. |
| Your Signature | Type or write your signature. |

Please return this Screening Form to:

Information provided to support a request for services may be shared with other professionals within Children and Family Health Devon, relevant health and social care organisations and agencies. This may also include children’s centres and education. Information is only shared on a need to know basis and always to ensure the care of the child/young person. Sharing information will always be completed securely and in line with Data Protection and Caldicott Principles. You can request that we do not share personal information at any time; however this may affect our ability to provide service. For more information about how we will use the information that you (or the service user) provide and your rights relating to this information (including the right to obtain copies of the information) please go to [www.childrenandfamilyhealthdevon.nhs.uk](http://www.childrenandfamilyhealthdevon.nhs.uk) or speak to a member of staff or write to us using the address on this letter.

**If you would like this letter or information in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know on the above address, email or telephone number.**

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| To be completed by Clinicians | | |
| Agreed |  | Notes. |
| Not Agreed |  | Notes. |