The CLDN Team can offer evidence based specialist nursing support to children and young people with a learning disability aged 0-19, who have a G.P within the Harrogate and Rural District or Hambleton and Richmondshire.

The CLDN Team support families in relation to behaviour, sleep, continence or other health needs.

We accept referrals from a registered health professional.

Please return this referral form to:

Children & Young People’s Specialist Community Nursing Team

Child Development Centre

Harrogate District Hospital

Lancaster Park Road

Harrogate

HG2 7SX

[hdft.ccnt@nhs.net](mailto:hdft.ccnt@nhs.net)

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| --- | --- | --- |
| Name of child:  Ethnicity: | Date of birth:  Interpreter Required? Y/N  If Yes which language? | Male / Female: |
| Name of Next of kin: | Parental responsibility:  Yes / No | NHS No: |
| Address: Telephone:  Mobile:  Postcode: Email: | | |
| GP Name: Address:    Postcode: Telephone: | | |

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| --- | --- | --- | --- | --- |
| **Other Professionals Involved** | **Yes/No**  **Please indicate** | **Name if Known** | **Consent to contact**  **Y/N** | **Contact Number** |
| **School/Nursery** |  |  |  |  |
| **Social Worker** |  |  |  |  |
| **CAMHs** |  |  |  |  |
| **Early Help** |  |  |  |  |
| **Paediatrician** |  |  |  |  |
| **School Nurse** |  |  |  |  |
| **Voluntary Services** |  |  |  |  |
| **Therapy Services** |  |  |  |  |
| **Other** |  |  |  |  |

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| Does this child have an EHCP? Yes/No  (Please enclose a copy, as without this we may have to return the Referral Form)  Has the Child/young person had universal services involvement to support the reason for referral? Yes/No  Have parents attended any parent support groups or training such as Sollihull Approach, Unlocking Autism or Sleep training?  Please include dates of course Yes/No  Have any other services previously been involved to support the family?  Please give details Yes/No |
| Is the child a subject of a Child Protection Plan in place? Yes / No  Please confirm that you have discussed this referral with a parent/guardian with parental responsibility: Yes / No  Have you obtained parental consent to share information with the Children’s Learning Disability team? Yes / No  Description of child’s diagnosed learning disability / condition  (Please give date and details of diagnosis.)  ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………  Reason for referral: (Please use additional sheets if required)  ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………  What would child/young person/parent like to achieve with support from the Learning disability nursing team?  ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… |

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| Date of referral |  |
| Name of referrer |  |
| Designation |  |
| Address |  |
| Postcode |  |
| Tel No |  |
| Email |  |