Referral Form
Community Learning Disabilities Service

If you have a learning disability and want help with your health, please fill in this form.

You might want to ask a carer or support worker to help you

About You

What is your name? ........................................................................................................

What is your date of birth? ....................................................................................

House Number: ........................................................................................................
Street: ......................................................................................................................
Town: ......................................................................................................................
Post code: ............................................................................................................... 

Telephone Number: ................................................................................................

Do you live alone?

YES ☐

No ☐ I live with ........................................................................................................

..............................................................................................................................
About Your Health

Has your health changed?

- Are you in pain?
  - YES
  - NO

- Which part of your body is sore?
  - YES
  - NO

- Have you been eating less?
  - YES
  - NO

- Have you been sleeping ok?
  - YES
  - NO

- Have you been feeling sad?
  - YES
  - NO

Please tell us more here

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How have these changes made you feel?

- Upset
- Angry
- Sad
- Tired
- Worried
- Not sure

[Images with thumbs up and thumbs down]
What things are you doing to make yourself feel better?

Are you eating healthy food?

- YES
- NO

Are you doing exercise to keep fit and healthy?

- YES
- NO

Have you tried talking to your carer or family about how you are feeling?

- YES
- NO

Have you talked to your doctor about your health?

- YES
- NO

Please tell us more about this below:

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Who looks after you?

Who is your carer or guardian?

Name: .................................................................

Where does your carer or guardian live?

House Number: ....................................................
Street: ....................................................................
Town: ....................................................................
Post code ..................................................................

Telephone Number: ................................................

Is it ok for us to contact your carer or guardian?

YES □ NO □

Who is your GP?

GP is another name for your doctor.

Name: Dr. ..............................................................

Surgery Address: ....................................................
..............................................................................
Once you have answered all the questions please send this form to:

Referral Co-ordinator
Lynebank Hospital
Halbeath Road
Dunfermline
KY11 4UW

If you would like to ask a question about this form

Please telephone

01383 565230

We will be happy to help you

For more information go to our website

www.dwfchp.scot.nhs.uk/healthservices

Quality assured by Good Information Fife Team.
www.nhsfife.scot.nhs.uk/easyread