**Please complete all parts of this form and return to:**

**Learning Disability Accessible Clinic**

Email – admin.ldnorth@nchc.nhs.uk

Subject – LD vaccination clinic

**Questions in Red are mandatory. Not completing could delay or prevent acceptance of referral**

|  |
| --- |
| **Patient Details** |
| First Name |       | Surname |       |
| Address |       | Date of Birth |       |
| NHS Number |       |
| Ethnicity |       |
| Postcode |  | Who determined this?       |
| Telephone |       | Gender  |       |
| Is patient on the GPs LD register? | Y [ ]  N [ ]  | Date of latest annual health check |       |
| COVID-19 vaccination status:  |
| 1st injection | [ ]  Yes / No [ ]  | Date:       |
| 2nd injection | [ ]  Yes / No [ ]  | Date:       |
| [ ]  Status Unknown |  |  |  |
| The patient needs an [ ]  interpreter (Language:       ) [ ]  Lipspeaker [ ]  BSL interpreter |

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| **Consent** |
| Has the service user consented to this referral? | [ ]  Yes [ ]  No |
| If consent has not been given, please explain why: |
|       |

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| --- |
| **Referrer Details** |
| Name |       | Telephone |       |
| Address |       | Relationship to client: |
|       |

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| **GP Details** |
| Name |       | Telephone |       |
| Address |       |

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| **Referral Information** |
| Please state principal carers/agency supporting the service user and details of who will be supporting access to vaccine clinic (please include contact details): |
|       |
| List of allergies:      |
| History of anaphylaxis or unexplained anaphylaxis:      |
| List of other diagnosis or heath conditions:      |
| List of all medication (please make clear any anti-coagulants or blood thinners): |
|       |
| Evidence of any current or past risks to self, others or property: |
|       |
| **Reason for referral:** **Please note**: It is important to mention any known risks to service user or others, known needle phobia, communication needs, any reasonable adjustments required: |
|       |