Contact our Referrals Team
0330 0581 881 dt.referrals@nhs.net

Referrals Enquiry Form

The Disabilities Trust
www.thedtgroup.org

Type of Service Required

- ( ) Independent Hospital
- ( ) Residential Rehabilitation
- ( ) Supported Living
- ( ) Residential Care Home

Other

X

Referrer's Information

Full Name	X
Role	X
CCG / Local Authority or Company	X
Contact Telephone	X
Contact Email	X
Funder's Name	X
Funder's Title & CCG / LA / Company or Private Funding	X

Reason for Referral

X

About the Individual

Full Name	X
Date of Birth	X
Gender	X
Current Address/Placement (Include Ward or Unit name)	X
Current Clinical Lead / Case Manager	X
Current Clinical Lead - Tel	X
Current Clinical Lead - Email	X
Diagnosis	X
Date of ABI (If applicable)	X

Is the person detained under the Mental Health Act? ( ) Yes ( ) No

Is a current report or other relevant reports and/or documents available to help us assess? ( ) Yes ( ) No

If Yes, please send a copy to **dt.referrals@nhs.net** so it can be sent to the Clinical MDT.

Thank you, we will be in touch shortly.

The Referrals Team,
The Disabilities Trust

Office Purposes Only

Date Referral Received	X
Name of Person Responding	X
Service(s) Considered	X
Date Referral Sent to Service	X
Outcome	X