## Appendix C – Learning Disability Screening Tool

### IDENTIFYING WHETHER A PERSON MAY HAVE A LEARNING DISABILITY

<table>
<thead>
<tr>
<th>Person’s full name:</th>
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<tr>
<td>Person’s date of birth:</td>
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<tr>
<td>Name of person completing form:</td>
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<td>Date:</td>
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Please circle the appropriate response:

#### 1. HISTORY

Is there historical information documenting learning disabilities such as:

- a) Self-report e.g. that they went to a special school, or had extra support within mainstream school. Yes/No
- b) Did they get any O’levels, GCSE’s or other qualifications, e.g. BTEC, NVQ? Yes/No*

Please give details of subjects and grades:

- [ ] ..........................................................................................................................
- [ ] ..........................................................................................................................
- [ ] ..........................................................................................................................
- [ ] ..........................................................................................................................

- c) Do they have a statement of Special Educational Needs**? Yes/No
- d) Information from a family member e.g. information about special education, developmental delay, needing help etc. Yes/No
- e) Relevant information from other agencies, i.e. any previous IQ reports**, etc? Yes/No

Please comment: .............................................................................................................

- [ ] ..........................................................................................................................
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** If the person has seen an educational psychologist, please try to obtain the report, either from the client, their family, or by phoning the relevant educational psychologist for where they went to school.

Poole Ed Psych Dept – 01202 262275
Bournemouth Ed Psych Dept – 01202 456166
Dorset Ed Psych – 01305 224888
East Dorset Ed Psych Dept - 01202 870130

You may need to gain consent, in which the attached form can be used.

#### 2. TRAVEL

Inability or difficulties travelling on public transport independently and/or always coming to appointments accompanied by another adult. Yes/No

Please comment: .............................................................................................................

- [ ] ..........................................................................................................................
- [ ] ..........................................................................................................................
- [ ] ..........................................................................................................................
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LD IQ Screening Questionnaire
Updated: June 2015
3. LITERACY

a) Inability to write in their first language,  
   and/or
b) Writing minimal information only,  
   and/or
c) Reading words but limited understanding of what is read  

Please comment: ........................................................................................................
........................................................................................................................................

4. DEMANDS

a) Being overwhelmed by routine demands e.g. missing many appointments,  
   erratic appointment keeping - late, early, wrong day, odd excuses etc.,  
   and/or
b) Difficulty sequencing tasks or prioritising demands and activities.  

Yes/No

5. BACKGROUND INFORMATION

Does the person struggle to give a good background history about  
   themselves  
   Yes/No

Please comment: ........................................................................................................
........................................................................................................................................

6. FINANCES

Do they have problems managing money e.g. trouble giving change for a  
   pound, running out of money two days after being paid/receiving benefits,  
   poor budgeting skills, difficulty estimating costs.  
   Yes/No

Please comment: ........................................................................................................
........................................................................................................................................

7. SELF CARE

Do they need support to look after themselves within the home, on a day-to-day basis?  
   Yes/No

Do they need support with personal care?  
   Yes/No

Please comment: ........................................................................................................
........................................................................................................................................
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8. UNDERSTANDING

Do they use complex words that they don’t seem to understand the meaning of or covering up their difficulties (e.g. forgetting glasses so that they can’t read etc).

Yes/No

Please comment: ……………………………………………………………………………………………

9. LEVEL OF SUPPORT

Does the person rely on others for help and support (e.g. help with using public transport, doing the shopping, helping with budgeting etc.)

Yes/No

Please comment: ……………………………………………………………………………………………

10. ADDITIONAL INFORMATION

Is the person able to do paid work that allows for full independence without benefits?

Yes/No*

Is the person able to drive?

Yes/No*

Medical history:
Has the person suffered from any head related injuries in the past?

Yes/No

Were there birth complications?

Yes/No

Have there been any other diagnoses in the family (mental health/genetic conditions)?

Yes/No

Please comment: ……………………………………………………………………………………………

Once completed please return to a member of the relevant Community Learning Disability Team

For adults residing in Bournemouth:
Bournemouth Care Direct Community Care Services Town Hall Annexe St Stephen’s Road Bournemouth Dorset BH2 6EA

For adults residing in Christchurch and Ferndown:
Hillcrest 31 Slades Farm Road Bournemouth Dorset BH10 4EU

For adults residing in Poole and Purbeck:
Delphwood Ashdown Close Poole BH17 8WG

For adults residing in West Dorset:
1A Acland Road Dorchester DT1 1JW

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Consent to gather information

The Learning Disability Team has been asked to see if there is any way we can help you. To find out the best way to help, we sometimes need to talk to other people who know you.

We might ask questions about

- the things you are good at and the things you find more difficult
- where you used to live
- whether you have ever been in hospital or taken any medication
- other work people have done with you, such as assessments.

We might ask if we can see reports written by people working with you.

Any information we get is kept confidential or private.

This means that we will not tell other people about what we find out unless we are worried about you or someone else getting hurt.

It is ok for __________________________________________ (name of psychologist)

To speak to and get reports from: 

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>my Doctor</td>
<td></td>
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<tr>
<td>my Social Worker</td>
<td></td>
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<tr>
<td>my School or Educational Psychologist</td>
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<tr>
<td>other_______________________</td>
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Signed: ____________________________  Date: ________________

Name: _______________________________  Date: ________________
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To be completed by health or social care professional if the individual DOES NOT have the capacity to consent for background information to be gathered.

______________________________ (patient name) does not have capacity to consent for background information to be gathered because:

- He/she is unable to understand the information relevant to this decision
- He/she is unable to retain the information relevant to this decision
- He/she is unable to use or weigh the relevant information as part of the process in making the decision
- He/she is unable to communicate his/her decision

Tick if applicable

It is the opinion of (list relevant professionals and others including family where relevant):

________________________________________

________________________________________

________________________________________

that it is in ___________________________ (patient name) best interest for this information to be gathered.

Signed: ________________________________ Date: ____________
Name: ________________________________ Date: ____________

Please return the completed referral and consent to gather information forms to the appropriate Learning Disability Psychology Team