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|  | | **Community Neurology Service Referral Form**  **Please complete the referral form fully. Incomplete forms will be returned.**  **E-mail referrals to:** [**sirona.neuro@nhs.net**](mailto:sirona.neuro@nhs.net) **0300 125 5550** | | |
| Date of Referral:  Has the person you are referring consented to this Referral?  Yes o No o  All referrals to this service are based on assumed consent to access your GP / medical records and share information as required under the strict rules of GDPR. | | |
| Profession(s) you are referring to: | | **Occupational Therapy** o  Physiotherapy o  Speech and Language Therapy (SLT) o  *\*NB If your referral is solely for SLT and no other profession is needed, please go to* [remedy pathway (icb.nhs.uk)](https://remedy.bnssg.icb.nhs.uk/adults/speech-language/slt-community-services/) *and complete the relevant form. Do not continue with this form.* |

Person you are referring:

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| --- | --- |
| Name:  Address:  Postcode:  Mobile: Landline:  Email:  First Language: | NHS Number:  Date of Birth:  Next of Kin’s (NOK) Name:  Relationship to Person:  NoK’s Contact Details/Access:  Consent to contact NOK as required  Yeso Noo |
| Patient’s current location/address  (If different from home address): | Are there any cultural, religious or practical needs that we should be aware of before our visit? |
| Preferred method of contact:  Mobile o Landline o Email o  Consents to receive text messages o  Consents to receive emails o  *Please note: the internet is not deemed a secure form of delivery for sending identifiable data unless the information in encrypted. Information can be transmitted via email providing the service user completes an email consent form to declare that they are happy for the information to be transmitted and that they understand the risks to the confidentiality of that information* | |
| **Cognition or sensory difficulties (memory/hearing/visual impairment):** | |

Referrer/Person’s GP Information:

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| --- | --- |
| Referrer’s Information | Person’s GP (if referrer not GP/GP Practice): |
| Referrer’s Name:  Profession:  Address:  Postcode:  Contact Telephone Number: | GP Name:  GP Practice:  GP Telephone Number:  Consultant (if applicable): |

Referral Details

|  |  |
| --- | --- |
| Current diagnoses:  Include GP summary and any relevant reports | Relevant Past Medical History: |
| Allergies: |
| Social Situation i.e. lives alone, care support etc. | Hazard / Risks in the home environment: |

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| ***If referring to SLT, please complete this section:***  **Reason for referral:** | |
| Swallow 🞏 | NBM or risk of NBM 🞏 Swallowing with difficulty 🞏  Choking with solids 🞏 Coughing with solids 🞏  Coughing with fluids 🞏 Repeated chest infections 🞏 Weight loss 🞏  If choking, please detail intervention required …………………………….  ………………………………………………………………………………… |
| Current dietary status | Oral 🞏 NGT 🞏 PEG/RIG 🞏 Subcut/IV 🞏 |
| Communication 🞏 | Difficulties understanding 🞏 Difficulties speaking 🞏  Difficulties communicating 🞏 |

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| What are you / the person you are referring hoping to achieve? |
| Please provide your reason for referral and any other relevant information: |

**e-mail to: sirona.neuro@nhs.net** **Tel: 0300 125 5550**