**NORTH SOMERSET MS SPECIALIST NURSE**

 **Community Neuro Service Referral Form**

**(DO NOT COMPLETE THIS FORM IF IN BRISTOL OR S GLOS).**

*Please note there is no MS Nurse service in Bristol & South Glos*

**Please complete the referral form fully. Incomplete forms will be returned.**

**E-mail referrals to:** **sirona.neuro@nhs.net**

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| --- | --- | --- |
| **PLEASE PRINT**Name  | Title M/F | Ethnicity  |
| Address Postcode | DOB |
| NHS No. |
| GPAddress |
| Tel No. | Consultant |
| Mobile No.Email address:  | Hospital |
| How does patient prefer contact? Phone, email, text*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* |
| Additional Contact Details/Next of Kin:NameAddress Tel No. |
| **1.** Reason for referral |
| **2.** Present condition (incl. date of diagnosis and effect on daily life, eg mobility, personal care, employment) |
| Is Client aware of diagnosis? | Type of MS (if known) Primary progressive   Relapsing/remitting  Secondary progressive |
| **3.** Medication DosageDisease modifying therapies (past or presently using)  |
| **4. Past Medical History** |
| **5.** Home situationLives with Type of accommodation Bungalow / House / Flat  Rented / Owner occupied AdaptationsOther relevant information eg Social Care Package, Social Worker |
| **6.** Other services involved at present & in past (including voluntary organisations) |
| Does the Client present any know risks to themselves or the safety of staff? Yes/No**(Please contact us with relevant details)** |
| Client aware of and agreeable to referral being made to MS Specialist Nurse? Yes/No**(NB Referrals cannot be accepted without patient’s consent.)** Please tick box to confirm this has been obtained  |

|  |  |
| --- | --- |
| Name of referrer (please print) | Designation |
| Address | SignatureDate of referral |
| Contact tel no./email/fax |  |

**Once referral form complete please e-mail to:**

**sirona.neuro@nhs.net**

**Tel: 0300 125 5550**